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FEBRUARY 1949

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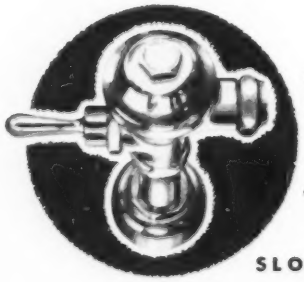

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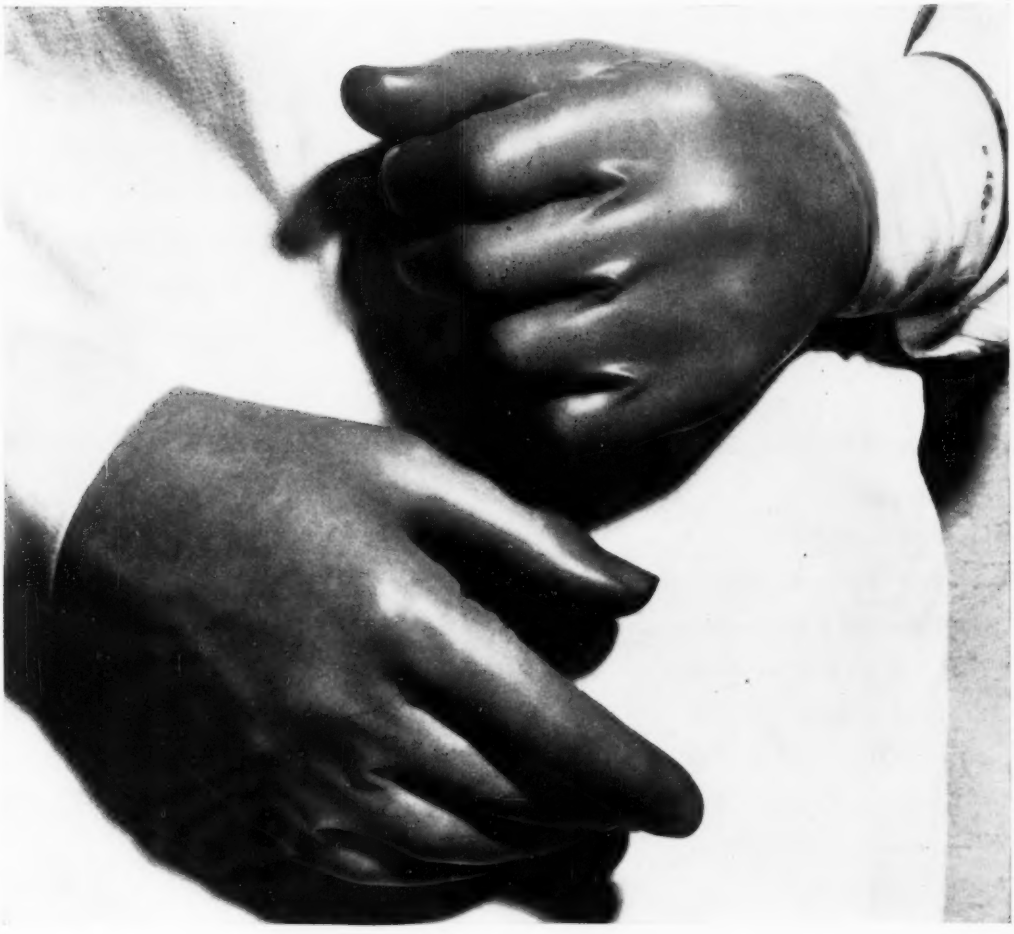

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FEBRUARY 1949

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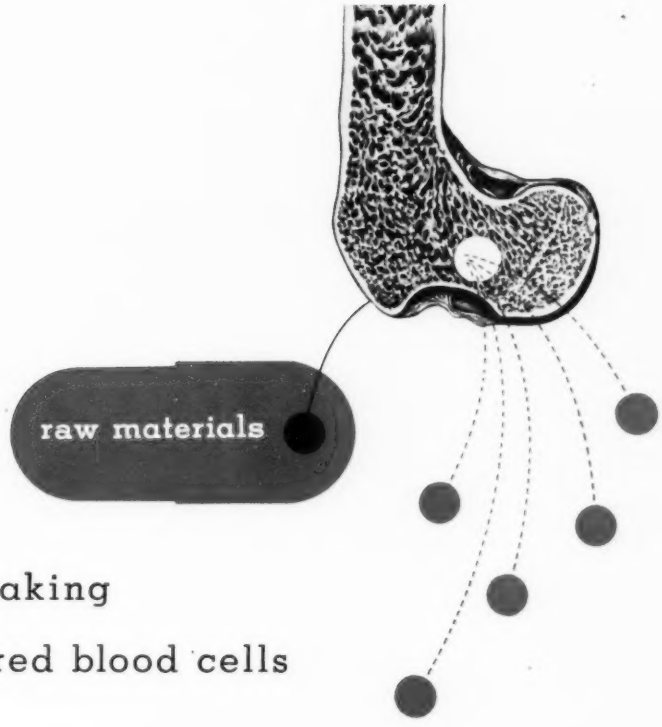

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AMONG THE AUTHORS

Dr. H. N. Bundesen

Now president of the Chicago Board of Health and trustee of the Municipal Tuberculosis Sanitarium there, **Dr. Herman N. Bundesen** has been a public health official in Chicago since 1914, when, a few years after graduation from Northwestern University Medical School, he joined the health department as epidemiologist. He has served terms since then as city health commissioner, health director for the Sanitary District and coroner of Cook County, and has been president of the board continuously since 1931. Widely known for his books and articles on infant care, Dr. Bundesen also writes a daily column of health advice reaching millions of newspaper readers all over the country, and monthly articles in the *Ladies' Home Journal* dealing with problems in all phases of child care. He is a lecturer in public health administration at the University of Chicago, a past president of the American Public Health Association and a fellow of the American College of Physicians. Among his best known achievements is the contribution to infant welfare described in his article on page 66.

J. A. Blaha

J. A. Blaha is administrator of the Lockport City Hospital, Lockport, N.Y., a position he took over two years ago after serving twenty years as business manager of the Grand View Hospital at Ironwood, Mich. Mr. Blaha was born and educated in Michigan, where he entered the field of hospital administration via the public accounting route. While in Michigan, he was a director of both the Blue Cross and Blue Shield plans, and he serves now as a director of Western New York Hospital Service Corporation. He is a member of the American College of Hospital Administrators. Mr. Blaha's article on food service appears on page 96 of this issue.

Charles E. Nyberg is a member of the staff of the newly organized and rapidly growing Academy of General Practice, which has established headquarters at Kansas City, Mo. Before joining the academy, Mr. Nyberg was business manager of the Danville Polyclinic at Danville, Ill., whose facilities he describes in an article on page 51 of this magazine. A graduate of Northwestern University, Mr. Nyberg served for several years in the bureau of medical economics of the American Medical Association, a position he left to join the navy in 1942. He took part as a line officer in both the Normandy and Southern France invasions in the summer of 1944, then went to the Pacific to help the navy polish off the war with Japan. After his discharge, Mr. Nyberg served for a while as assistant secretary of the American College of Radiology before going to Danville.

Jean A. Lyons

Jean A. Lyons left her position in a Michigan advertising and public relations office five years ago for a full-time career as homemaker and mother. Her interest in hospital affairs dates back to prewar years, when she handled publicity for the united hospital financing campaigns in her home city. This work gave her an insight into the problems of hospital management and a deeper appreciation for the effectiveness of the hospital in the community. The program which she discusses in this issue (page 71) recalled her old enthusiasm for the rôle of the hospital in community life. Not wanting to lose touch with her career Mrs. Lyons now carries on a small portion of her former work from her home and contributes an occasional magazine article.

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Reader Opinion

Workers and Unions

Sirs:

I read with great interest the article entitled "Do Unto Employes as the Union Would Do—But Do It First" by S. A. Ruskjer in the November issue of your magazine. The advice that Mr. Ruskjer offers to his fellow administrators is, on the whole, sound and certainly hospital employes would appreciate working under the improved conditions which he envisages.

However, I am somewhat disturbed by the implication of the article—and note especially its title—that the organization of hospital employes into unions is essentially a terrible thing which must be avoided at almost any sacrifice, even that of granting better wages and working conditions to employes. I think this attitude on the part of Mr. Ruskjer and some of his fellow administrators is certainly unfortunate and often is directly responsible for the difficulties that ensue when hospital employes are first organized. It is an attitude that reflects the thinking of the robber barons of the last century, and it is strange that it should be found in a group of people who for the most part are not owners of the properties they administer.

Incidentally, Mr. Ruskjer's reference to the relative unimportance of wages in the interests of the American workers certainly cannot be substantiated from reality. Reference to "a large scale survey" to discover which items are of greatest concern to the American worker is, I believe, a reference to a poll released by Claude Robinson, author of the notorious and thoroughly discredited poll on the Taft-Hartley Act which was published by *Look* magazine last year. It doesn't seem wise to use pollsters' opinions on these vital matters after their abysmal failure to predict the results of the recent national elections.

However, whether the references are to Robinson's poll or not, a little examination of the list contained in Mr. Ruskjer's article will indicate how unrealistic it is. Does anyone believe that social security and old age security are of greater concern than wages to the average employe in his twenties? Does anyone believe that "uniforms suitable to the work performed" are more important than wages to any American worker?

I appreciate the fact that Mr. Ruskjer has said some relatively kind things about unions in his article, and feel that hospital employes in general would be much happier if his fellow administrators took his advice. However, I would like to predict that even if all of his suggestions were carried out, hospital employes would continue to organize into unions. Their doing so is simply another phase in the development of our growing democracy. Through unions, hospital employes and other workers acquire not only better wages and working conditions, but also a voice in the determination of those wages and working conditions, and a new improved status of our industrial society.

Anthony G. Weinlein
Building Service Employees International Union
Department of Research and Education
Milwaukee

The title of Mr. Ruskjer's article was added in our offices. To the extent that

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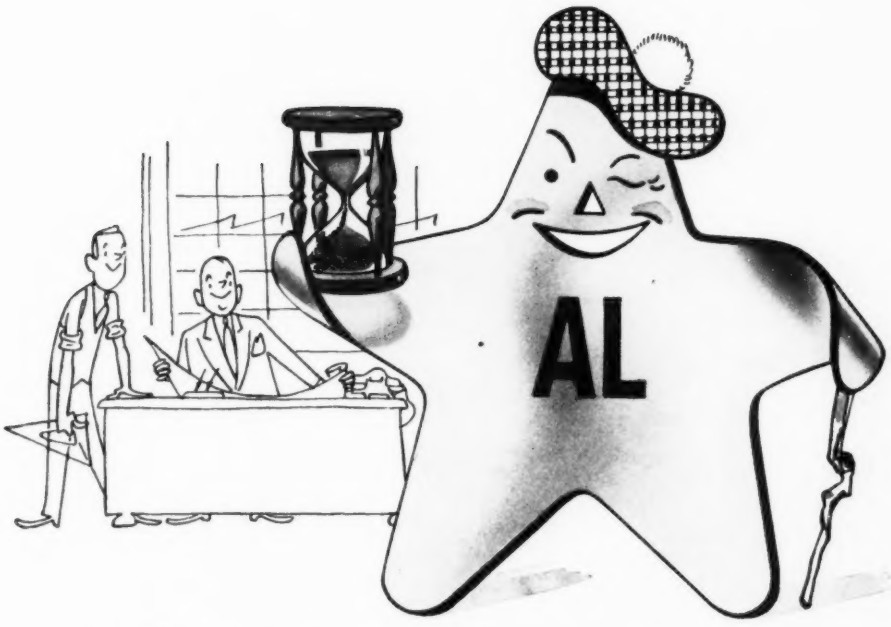

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it had any offensive implications, the fault is entirely ours and not the author's.—ED.

Sirs:

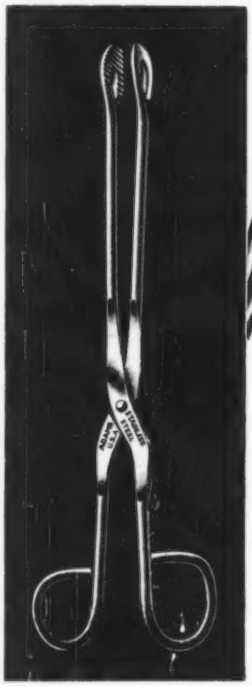
Naturally, I have been interested in trying to discover any real objections that might be in Mr. Weinlein's mind with reference to the contents of the article. I am sure that he means to be fair and consistent in the criticisms he offers. However, I experience real difficulty in attempting to follow him in the reasoning set forth in his letter. First, let me assure him that the poll he so very vehemently takes exception to is not the poll referred to in my article. Isn't it a bit inconsistent to condemn all polls just because some polls missed the mark in trying to determine the sentiment of the American voter just previous to the recent general election?

I wonder if it has occurred to Mr. Weinlein that those polls might have been quite accurate measuring rods at the time the polls were taken and that the reason why the election returns were not recorded as the polls had previously indicated might stem from the fact that voters experienced a change of mind on the very eve of the election? At any rate, so far as polls are instrumental in ascertaining the law of averages, they do make a definite contribution. The law of averages is a pretty stubborn law to deal with and I sincerely believe that the law of averages makes it very evident that there are several considerations of greater importance to the employe than the exact size of the pay roll. Employes desire to have the privilege of living a normal life, taking their place in the society that surrounds them. They desire a comfortable place to live, a comfortable bed to sleep in, good meals of nourishing food. They desire to be dressed properly both on and off duty.

Mr. Weinlein seems to think that we should be realistic in our approach to the problem and I certainly agree, but I do not agree that he is realistic when he quotes the attitude of workers in their twenties with reference to social security and a suitable retirement plan. Naturally, the workers in their twenties have not reached the place where social security and a retirement plan loom up as largely in their thinking as they do in the thinking of older employes. However, if he will keep an ear close to the ground, he will discover that even in their twenties, employes are beginning to give considerable thought and attention to their future security. However, in my thinking, he wandered far afield with a desire to be realistic when he made reference only to the workers in their twenties as being typical of the attitude of the average American worker toward social security and retirement plans.

I must differ very sharply also when he brushes aside the matter of suitable uniforms for employes as having any large place in the thinking of employes. A suitable uniform, kept laundered, cleaned and pressed by the employer for the employe does take on real importance in influencing the mental attitude of the worker and tends to produce institutional pride in the employe. The wearing of a suitable uniform naturally takes on greater importance in such institutions as the hospital, where the color and type of uniform are indicative of the department in which the employe works, such as dietetic, housekeeping, nursing aides, technicians.

Naturally, I am wondering if Mr. Weinlein has ever given careful study to the fundamental difference between working in a hospital in contrast to a commercial institution. The hospital



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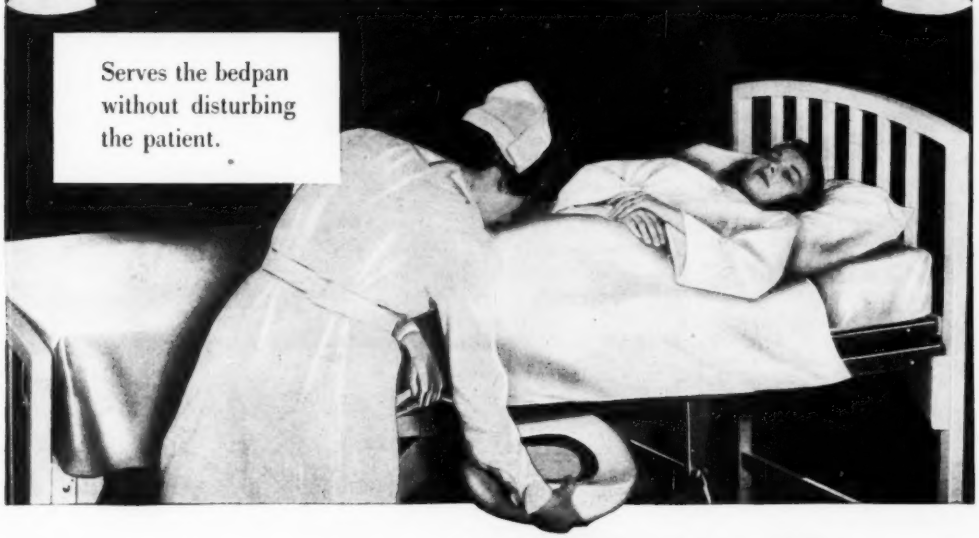

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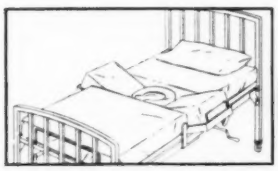

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cannot successfully do its appointed task and rightly fill its place, responding to the need of society, without the presence of the spirit of philanthropy and benevolence, in contrast with a cold blooded steel and iron operation in a commercial institution no matter how high the ideals of the commercial institution are in the direction of turning out a first class product. In the one case, the clock may govern every mechanical operation, whereas in the hospital, there constantly looms up uncalculated obligations that must be met and, if not met, must result in irretrievable loss to some human life.

The hospital is dealing with not only flesh and blood, but spirit. The hospital is dealing with life and death and all those connected with the hospital, if they are to be a real success and measure not only with calculated but also uncalculated obligations, must have learned the secret of cheerfully going the second mile. Responding to uncalculated obligations always involves the spirit of "Whatsoever thou spendest more I will repay thee," as illustrated in the experience of a Good Samaritan. In hospital work, we never reach the place where we say we have done all we could. As long as there is a spark of life left in the patient, unselfish, earnest efforts are put forth to save the patient's life. Every employe in the hospital organization becomes a part of the total effort which centers itself in the healing of the body and the saving of the life.

Unfortunately, throughout the history of the American hospital, the heavy load of charity borne by the hospital has too often been borne by the employes of the hospital, whereas the burden of such charity should be shared by the entire community. It is perfectly proper and essential to develop and strengthen the spirit of charity, philanthropy and benevolence in the bosom of each employe in the hospital, but it is not fair to such employes to carry the full burden that a large load of charity throws upon the hospital.

I think that Mr. Weinlein is already aware of the fact that hospital leaders of today are conscious of the need of bettering the lot of the hospital employe, but in so doing, the hospital must not be turned into a cold blooded commercial institution. The spirit of a Florence Nightingale, Edith Cavell or a Clara Barton must be fostered and kept alive within the hospital program and the lamp of charity and benevolence and self-sacrifice must be kept burning brightly or our modern hospital will utterly fail in accomplishing the task so clearly enunciated and illustrated in the teachings and example of the greatest human benefactor this world has ever known. He may rest assured that hospitals are making progress in the direction of a more consistent program for their employes, including not only wage considerations, but improved working conditions, working hours, living conditions, social opportunities, building up an environment of cheerfulness and the family spirit, in which our employes shall be happy as they contribute so largely toward a successful medical, nursing and hospitalization program, not only ministering to those who are sick, but helping the well to enjoy still better health.

S. A. Ruskjer
Deputy Director of Health
Louisville, Ky.

Wait for No Man

Sirs:

Probably you published the "Waiting for Operation" item from the *British Medical Journal* expecting to receive comments from a number of your readers, and undoubtedly you will not be disappointed.

The legal answer to the question given by the editor of the *B.M.J.* may or may not be typical of the matter-of-fact British point of view, yet it is neither complete nor satisfactory. Moral responsibility far outreaches legal necessity. If a patient with carcinoma of the stomach lost his chances for life while waiting six to twelve months for admission to a hospital, someone blundered, to say the least, and is morally guilty of criminal negligence. That is the principal point, and all else is secondary.

Every hospital that cannot admit surgical patients with a fair degree of promptness should obviously do two things: first, take heroic steps, if necessary, so as to have beds available at all times for emergency admissions, and, second, classify its reservations so that those in need of prompt surgery may have preference. A patient with cancer has rapidly diminishing chances for survival as time passes; if surgery is indicated it should seldom be delayed more than three weeks to a month. The responsibility for seeing that there is no unnecessary delay is primarily that of the surgeon and secondarily that of the hospital. Each should have remembered that "time, tide and illness wait for no man."

Robert N. Brough
Norwalk, Conn.

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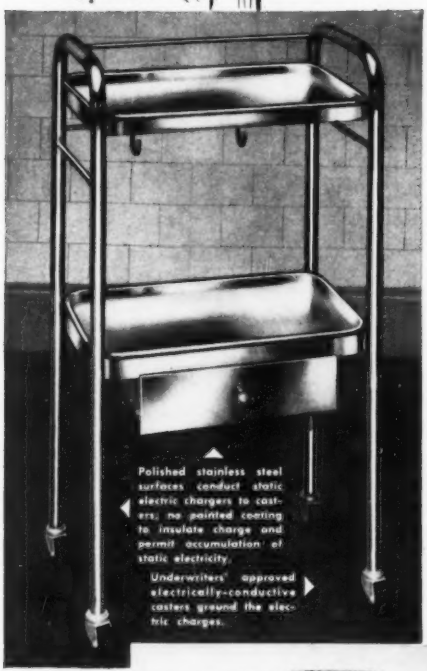

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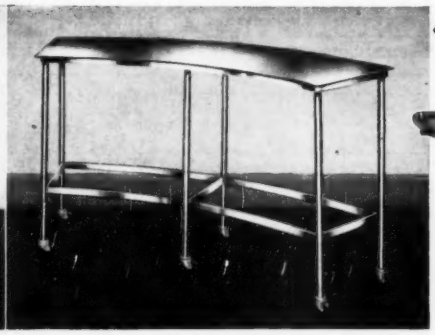

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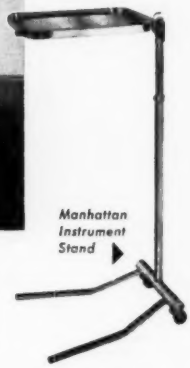

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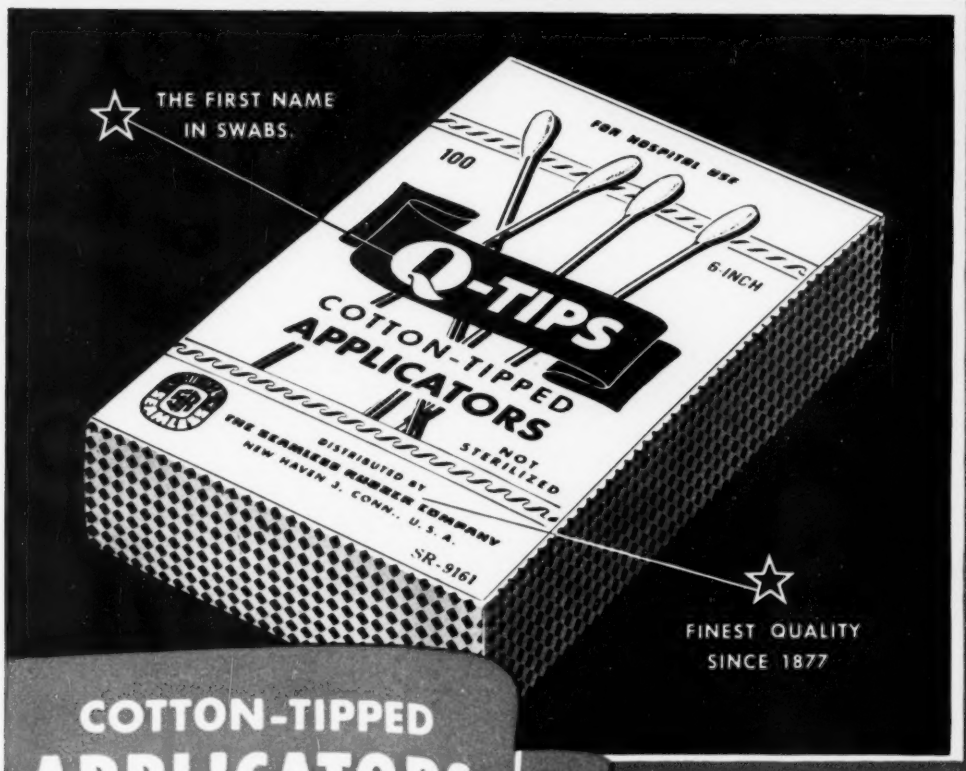


COTTON-TIPPED APPLICATORS

Conform to Federal Specifications GG-A-616

Q-TIPS HOSPITAL SWABS are made by Q-Tips, Inc., the originator and leader in the swab field — backed by over 20 years of *specialized* research and development.

Effective January 1, 1949, Q-TIPS Hospital Swabs will be distributed *exclusively* by SEAMLESS—through selected hospital supply dealers. Thus, you have *double* assurance of complete satisfaction; a first-quality product and the best possible service!

Write today for professional samples, price list and complete information.

SURGICAL DRESSINGS DIVISION

THE SEAMLESS RUBBER COMPANY

NEW HAVEN 3, CONN., U. S. A.

DESIGNED...
for superficial therapy...

Easily applied to all parts of the body.

The Maximar 100 was designed expressly for superficial therapy. The new Coolidge tube, with its beryllium window, is so mounted that radiation passes only through the tube window and the intervening air.

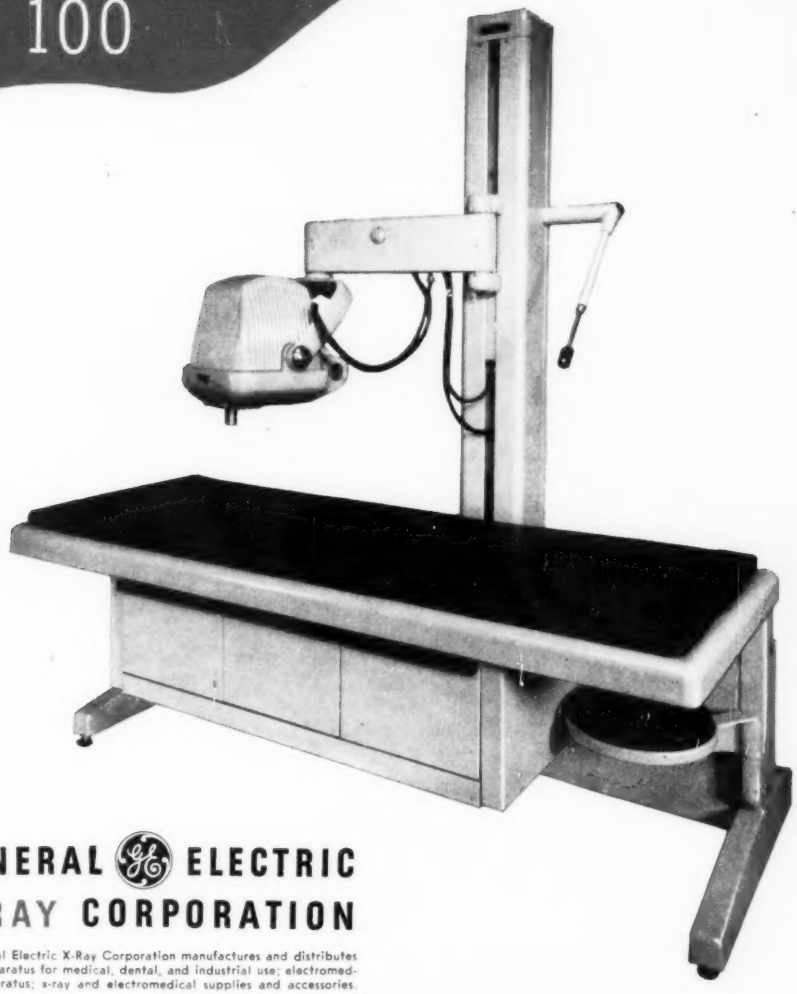
Because the beryllium window has an inherent filtration of approximately 0.1 mm aluminum, it makes available radiation of extremely soft quality. This soft radiation is absorbed in the superficial layers of tissue with a consequent reduction in the dose received by deeper tissues.

Another result of this low inherent filtration is high output. At 100 kvp and 5 ma. output is up to 900 roentgens per minute at a focal-skin distance of 30 centimeters. At 30 cm focal-skin distance, a 20 cm circle is covered. The intensity within 2 cm of the field edge is about 80 per cent of that delivered at the field center.

Add to these advantages the mechanical flexibility and electrical simplicity of the Maximar 100, and you will see why more physicians look to the G-E symbol when they invest in x-ray equipment.

FREE If you'd like to know more about the Maximar 100, write for our fact-filled booklet. General Electric X-Ray Corporation, Dept. B-12, 4855 W. McGeoch Ave., Milwaukee 14, Wisc.

the Maximar 100



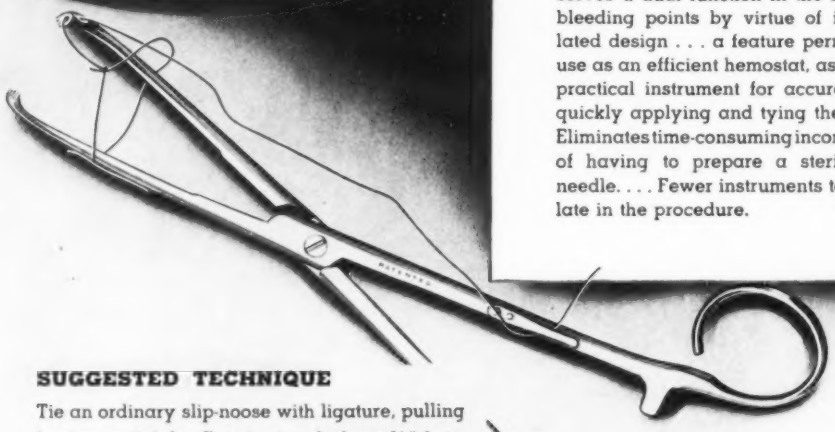
GENERAL ELECTRIC
X-RAY CORPORATION

• General Electric X-Ray Corporation manufactures and distributes x-ray apparatus for medical, dental, and industrial use; electromedical apparatus; x-ray and electromedical supplies and accessories.

Simplifies Management of Post-tonsillectomy Hemorrhage

The HOWARD TONSIL LIGATURE TYING FORCEPS

serves a dual function in the ligation of bleeding points by virtue of its cannulated design . . . a feature permitting its use as an efficient hemostat, as well as a practical instrument for accurately and quickly applying and tying the ligature. Eliminates time-consuming inconvenience of having to prepare a sterile suture needle. . . . Fewer instruments to manipulate in the procedure.



SUGGESTED TECHNIQUE

Tie an ordinary slip-noose with ligature, pulling knot very tightly. Cut short end about ⅜" from knot.

Thread the long end through the eye on the external surface near tip of one end of the jaws.

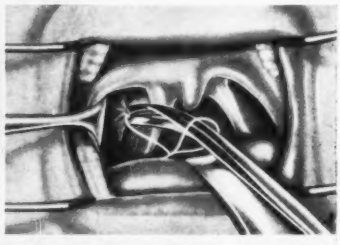
The noose of the ligature, which should be about 1" in diameter, is thrown over both jaws and held out of grasp by the latter by a steel spring clip on the jaw opposite the one with eye.

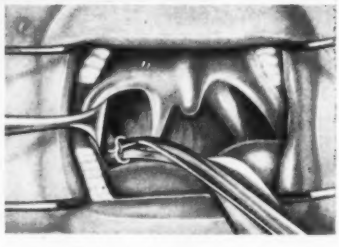
Grasp the bleeding point of tissue in the usual manner and with a slow, even pull, parallel to the instrument, the loop is drawn gradually free from the clasp and around the bleeding point.

When tightly tied, relax the pull, open the hemostat and withdraw two or three inches and cut the ligature about ⅜" from the tissue.

If the ligature is cut long enough at the beginning, several vessels may be ligated without re-threading by simply tying a new loop after each tying operation, thus saving time and material.

A Kny-Scheerer quality instrument, precision-made for discriminating surgeons.

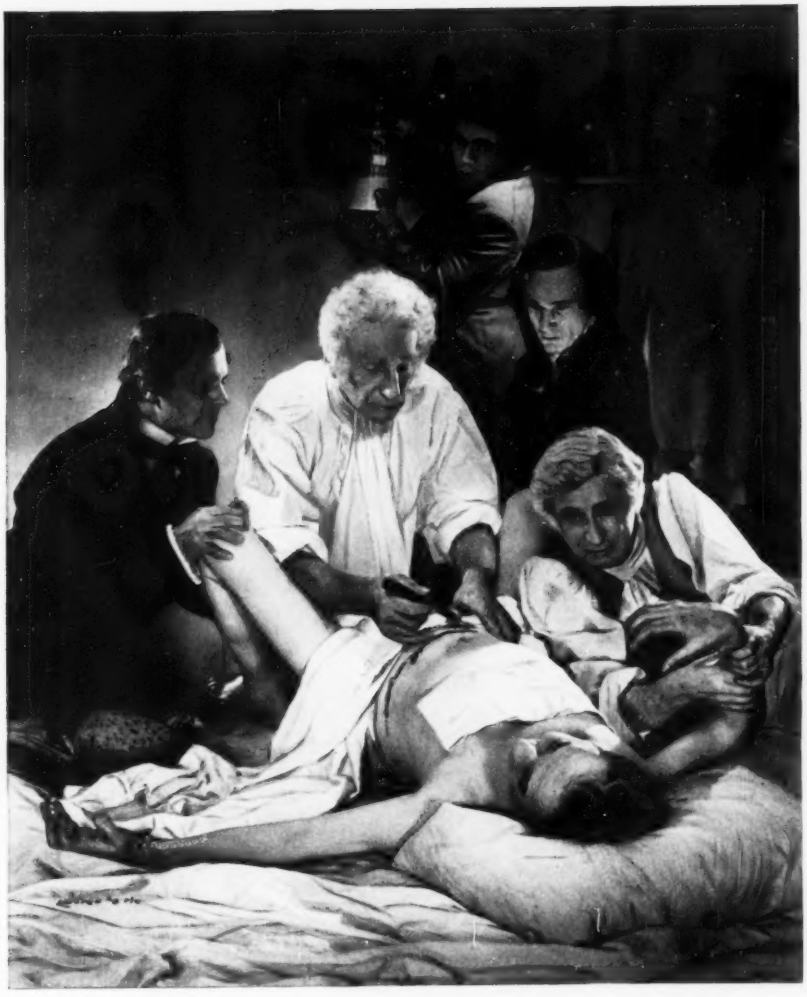




Illustrating the simple procedure of applying and tying ligature by means of the cannulated hemostat in cases where pressure tampon fails to control hemorrhage.

ORDER THROUGH YOUR DEALER
or write for further information

KNY-SCHEERER CORPORATION
483 First Avenue **New York 16, N. Y.**



Astley Paston Cooper

(1768-1841)

SUTUREGRAM

NUMBER ELEVEN IN A SERIES

Complications of Suturing with Nonabsorbable Sutures

(a) Foreign Body Sinus

Sinus forms about the nonabsorbable suture that does not slough from the infected wound

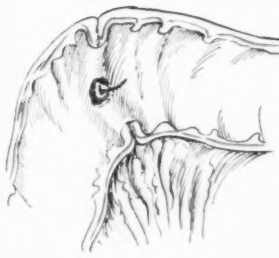
✓ Sinus is cured by mechanical removal or eventual sloughing of suture

SUTUREGRAM

NUMBER ELEVEN (CONTINUED)

(b) Ulceration

Nonabsorbable sutures may penetrate mucosa of intestine or stomach. Ulceration occurs and suture sloughs. Ulceration persists if suture remains attached

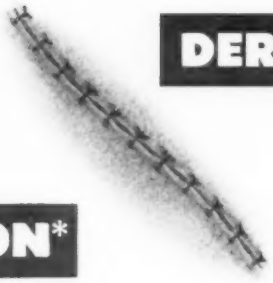


✓ Prevention: Use catgut; small bite interrupted sutures

(c) Calculus

Concretions may form on nonabsorbable suture hanging into urinary or biliary tract

✓ Prevention: Use catgut in these locations.



DERMALON*

D & G Sutures
Prepared from Nylon

SURGILON*

. . . produce minimal reaction

D&G Dermalon Sutures (processed from nylon monofilament) are smooth, uniformly round and absolutely non-capillary. They are unaffected by tissue fluids and free from irritating properties... produce minimal tissue reaction. Indicated for skin closure, tension suturing, plastic and dental surgery.

D&G Surgilon Sutures (braided nylon) are specially processed to render them non-capillary. They possess adequate strength and flexibility and proper elasticity—produce minimal reaction in tissue. Indicated for a wide range of applications as a buried suture; especially in artery, gastro-intestinal, nerve, plastic and thyroid surgery.

DAVIS & GECK, INC., BROOKLYN 1, NEW YORK

*Registered Trade-mark

ASTLEY PASTON COOPER (1768-1841)—A great surgeon and a great teacher, Astley Paston Cooper was largely responsible for making London the surgical center of the world in the early part of the nineteenth century. He was the first to ligate the abdominal aorta successfully, and the first to amputate a leg at the hip joint. His greatest contribution to surgery, however, was in advancing and putting into wide practice the principles of anatomy and surgery established by the pioneering John Hunter. Most famous of his published works is his *Treatise on Hernia.*

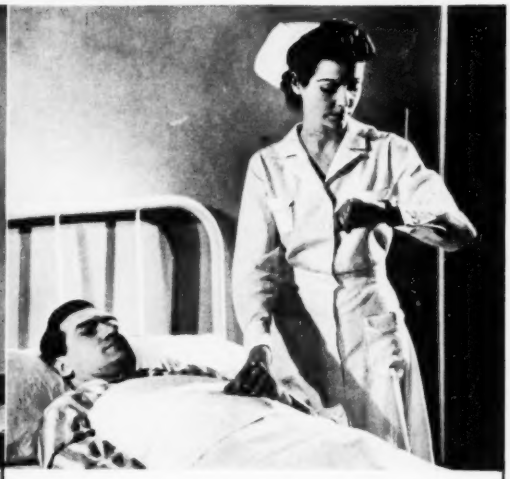
INDEX TO ADVERTISEMENTS

(HPF) after company name indicates that further descriptive data are filed in catalog space in HOSPITAL PURCHASING FILE—26th Edition

INDEX TO ADVERTISEMENTS

(HPF) after company name indicates that further descriptive data are filed in catalog space in HOSPITAL PURCHASING FILE—26th Edition

Count your blessings —and his



A Boon to Management — *because*

AIRFOAM mattresses last far longer than conventional types • Weigh less, more easily handled • Never need turning • Free from dust and lint • Can be washed with soap and water

A Boon to Patients — *because*

AIRFOAM mattresses are luxuriously comfortable • Cool, self-ventilating • Recommended for allergies • Do not sag or lump up • Reduce incidence of bed sores

AIRFOAM gives you super-cushioning

PRESS DOWN ON AIRFOAM and you'll feel a buoyant upward comeback. **Airfoam's** millions of resilient air cells breathe to balance body pressure with equal support—a uniform, self-adjusting support that insures super-comfort and perfect relaxation. Raise your hand and **Airfoam** instantly rounds back to shape—never looks crushed and saggy like conventional cushionings.

Above you see some of the reasons why so many leading hospitals are now specifying **Airfoam** mattresses when they buy. This buoyant latex material is available in full volume construction for mattresses, or special thicknesses for topper cushioning. Order from your supply house, or write direct to Goodyear, Airfoam Dept., Akron 16, Ohio.

*Airfoam**

by

GOODYEAR

THE GREATEST NAME IN RUBBER

*T. M. The Goodyear Tire & Rubber Company

Prove
CAMEL MILDNESS
for Yourself!

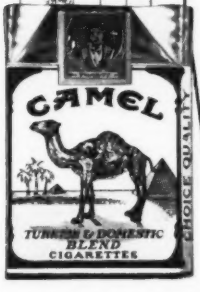
Money-Back Guarantee!

Test Camel Mildness for yourself in your own "T-Zone"—T for taste, T for throat. If, at any time, you are not convinced that Camels are the mildest cigarette you ever smoked, return the package with the unused Camels and we will refund its full purchase price, plus postage. *(Signed)* R. J. Reynolds Tobacco Company, Winston-Salem, North Carolina.

In a recent coast to coast test of hundreds of people who smoked only Camels for 30 days, throat specialists, after weekly examinations, reported:

"Not one single case of throat irritation due to smoking CAMELS!"

Hundreds of men and women were included in this coast to coast test. These men and women smoked Camels—and only Camels—for 30 consecutive days. They smoked on the average of one to two packages a day. Each week noted throat specialists examined the throats of these Camel smokers—a total of 2470 careful examinations. In every report, the findings of these throat specialists were the same—"not one single case of throat irritation due to smoking Camels."

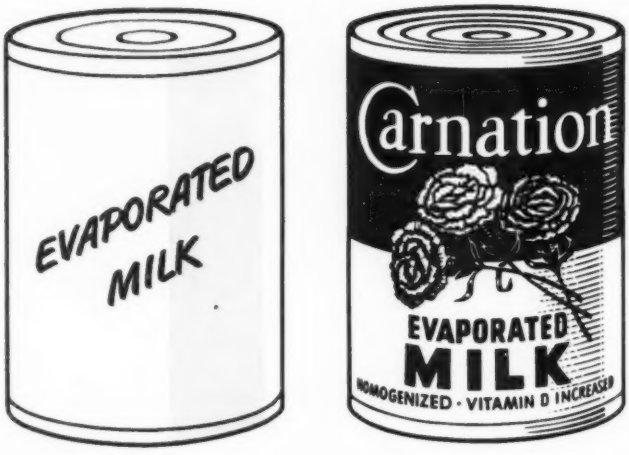


According to a Nationwide survey:

MORE DOCTORS SMOKE CAMELS

than any other cigarette

Doctors smoke for pleasure, too! And when three leading independent research organizations asked 113,597 doctors what cigarette they smoked, the brand named most was Camel.



Which would you prescribe for Infant Feeding?

NATURALLY, you'd choose a name you know . . . a name worthy of your confidence.

AND CARNATION *protects* your recommendation with the most scrupulous standards of safety, uniformity and nutritional value.

EVERY DROP of Carnation Milk is processed with "*prescription accuracy*" —in Carnation's *own* plants under Carnation's *own* continuous supervision. That is why you can have complete confidence in Carnation. It is evaporated, homogenized, enriched in vitamin D, and sterilized, under the most rigid controls. Constant tests and vigilant inspection are your guarantee that every can bearing the name Carnation meets the highest requirements of the medical profession.

NO WONDER nation-wide surveys show *more babies are fed on Carnation than on any other brand of evaporated milk.* It's the milk you can confidently *prescribe by name*—day in and year out.

Nation-wide surveys show that Carnation Milk is more widely used in infant feeding than any other brand of evaporated milk.

The Milk Every Doctor Knows

"From Contented Cows"

NOW—GREATER SAVINGS ON FAT COSTS!

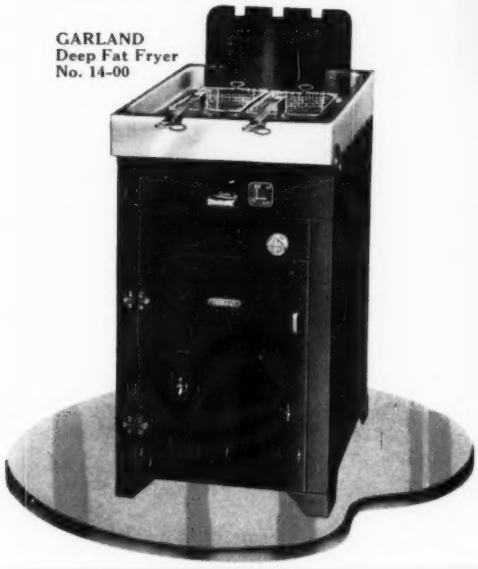
More and Better Fried Foods Faster!

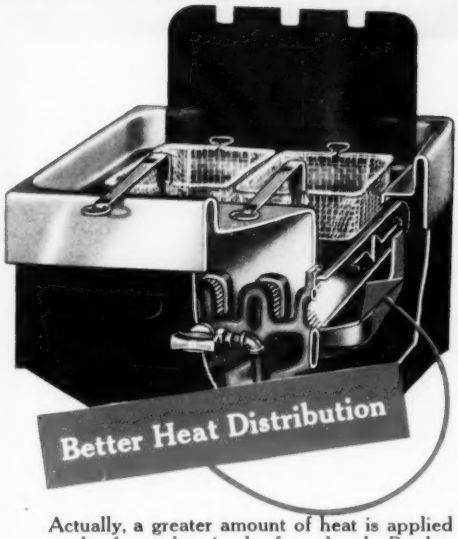
GARLAND

Improved low priced Deep Fat Fryer delivers sensational performance!

You'll hardly believe there could be such a difference in fryer performance. And when you compare the quality—get the *lower price*—you'll know your *best buy is Garland.* The Garland line leads in sales because it leads in *value!*

GARLAND
Deep Fat Fryer
No. 14-00





Actually, a greater amount of heat is applied to the four tubes in the fryer bowl. But because the heat is so evenly distributed over the tube area, fat is not subjected to extreme "spot" heat. Fat stands up longer. Cold zone temperature is considerably reduced.

HOW TO BUY! Consult your Garland Food Service Equipment Dealer. He can give you valuable ideas and advice. All Garland units are available in stainless steel and equipped for use with manufactured, natural or L-P gases.

Approved by the American Gas Association

GARLAND*

THE TREND IS TO GAS

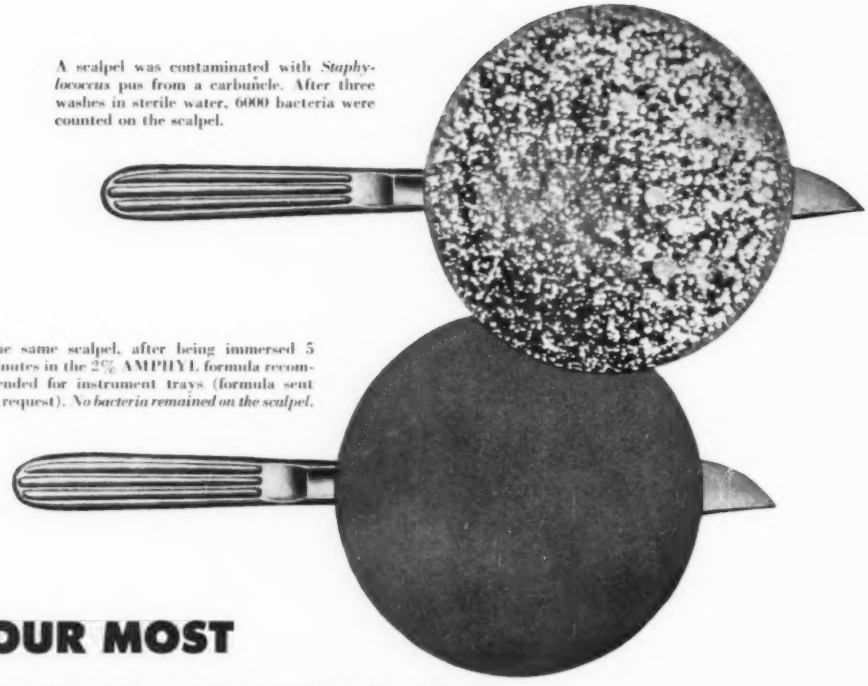
FOR ALL COMMERCIAL COOKING

Heavy Duty Ranges • Restaurant Ranges • Broilers • Deep Fat Fryers • Toasters
Roasting Ovens • Griddles • Counter Griddles

PRODUCTS OF DETROIT-MICHIGAN STOVE CO., DETROIT 31, MICHIGAN

*REG. U. S. PAT. OFF.

A scalpel was contaminated with *Staphylococcus* pus from a carbuncle. After three washes in sterile water, 6000 bacteria were counted on the scalpel.



The same scalpel, after being immersed 5 minutes in the 2% AMPHYL formula recommended for instrument trays (formula sent on request). *No bacteria remained on the scalpel.*

YOUR MOST DEVASTATING WEAPON IN THE WAR ON GERMS...

Amphyl
Reg. U. S. Pat. Off.
PHENOL COEFFICIENT 10

AMPHYL . . . only AMPHYL . . . combines these features— Non-toxic, non-injurious to human tissue. Effective in presence of organic matter. Mild, agreeable, *clean* odor. Rust preventative for instruments. Powerful surface-tension depressant. Concentrated potency permits high dilutions, low costs. ½% **AMPHYL** solution, recommended for disinfecting surfaces, costs only 2¢ per gallon. **AMPHYL** most frequently used in ¼% to 2% solutions.

NON-SPECIFIC AMPHYL eliminates all necessity of stocking several germicides for various specific purposes. Doctors already familiar with it praise **AMPHYL** highly for uses in surgery, obstetrics, gynecology, dermatology, dentistry, and unlimited general utility.

AMPHYL destroys
more deadly germs
more quickly
more economically!

AMPHYL— List price, $5.00 per gallon. *Save 20%* by buying a 50-gallon drum. Supplied in 1-gallon containers and in 5, 10 and 50-gallon drums. Leading hospital supply distributors are authorized to sell **AMPHYL**.

WRITE for samples of **AMPHYL** and detailed monograph for the medical and dental professions to your

HOSPITAL SUPPLY DISTRIBUTOR or to
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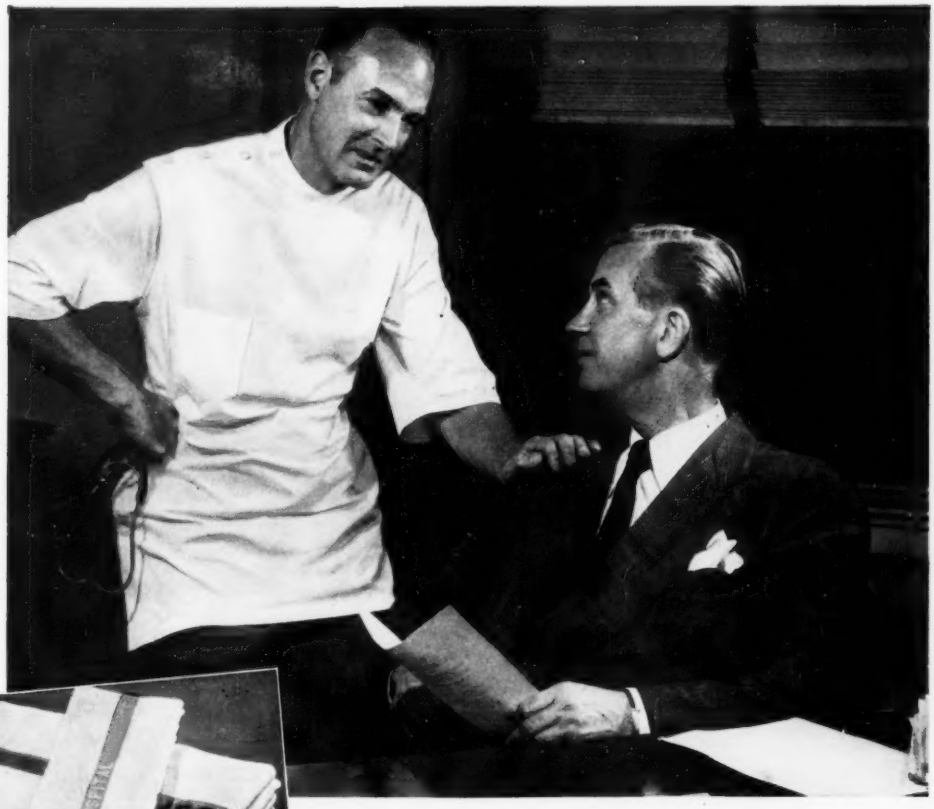
Hospital Department
445 Park Avenue, New York 22, N. Y.



Name Woven Terry and Huck Towels, Wash Cloths and Mats

Plain Terry Towels, Crash and Huck Towels and Toweling

"Take our name towels. They last"—

The superintendent and the surgeon relax for a moment. Says the surgeon—

"You look worried, Jim."

"Sure am. High costs, higher costs. Man! You have to be a Houdini to balance a budget these days—"

"Everything up?"

"Just about. We have to make things last these days."

"Can you?"

"Many things. Take our name towels. They last."

"What kind are they?"

"MARTEX"

Yes, MARTEX name-woven terry towels are built to last, to take brutal wear and repeated trips to the laundry. Their wear resisting construction starts at the foundation, in the plied yarn ground warp threads. Plied yarn ground warp threads are the basis of a durable towel.

On plain towels and toweling the name that is looked to for long, satisfactory wear is FAIRFAX. Sturdiness and ability to take hard usage have made FAIRFAX plain towels and toweling respected by economy seeking buyers. Carefully kept records of length of towel life in use would show that it is good practice to specify MARTEX name-woven and FAIRFAX plain towels and toweling on your purchase orders.

products of **WEST POINT MANUFACTURING COMPANY**
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"Unselfish Selfishness"

A FRANK SALES MESSAGE TO EVERY HOSPITAL EXECUTIVE WHO HAS TO DO WITH THE PLANNING OF NEW FACILITIES

Our purpose is selfish, to this extent—that we, whose business is the designing, planning and manufacturing of laboratory equipment, want you to buy such equipment from us, rather than from the contractor who furnishes your ordinary window sashes, doors and other millwork.

•

It would be idle for us to expect you to do that for any reason except to get the best laboratory procurable for your money. You may be sure that you will. Your gain will not be because of any difference in honest intent between our organizations and your local carpenter-contractor or door and window builder. It will be because we have the specialized knowledge and plant facilities needed, while he has not. (We could not, by the way, meet successfully *his* skills and techniques in *his* particular field).

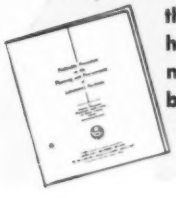
•

By prudently keeping your laboratory equipment specifications apart from the general building data, you will make it possible for specialists like ourselves to bid on your project without the penalty of having to add a middleman's compensation to our prices. You will be able to draw fully and without obligation on a truly vast fund of experience. You will get equipment better in dozens of important ways than your laboratory dollars can buy from the "general practitioner."

•

All of which, we submit, represents "unselfish selfishness." *Send for new Planning Booklet.*

May we send you this helpful new booklet?



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Laboratory Equipment Section

SCIENTIFIC APPARATUS MAKERS ASSOCIATION

Twenty North Wacker Drive, Chicago 6, Illinois

What would you do without Stainless?

THINK FOR A MOMENT and you'll have to admit that, without Stainless Steel, running a hospital efficiently would be a far, far tougher job than it already is.

For without Stainless Steel to make cleaning and sterilizing easier, your already over-worked staff would have more to do than ever. Without the protection that clean, sanitary Stainless Steel affords, the health of your patients and the comfort and well-being of your personnel would be less assured. Without strong, wear-resisting, non-rusting Stainless, your equipment would wear out faster, would require more frequent replacement and your high operating costs would rise still higher.

These are facts. We remind you of them because if they are overlooked and you decide to "save" the little extra that Stainless Steel might cost, you are leaving yourself wide open for future trouble and considerable disillusion, not to mention unnecessary expense.

So, when you plan to modernize or re-equip, use Stainless Steel wherever possible. And for best performance, use Stainless at its best—U·S·S Stainless Steel. More than likely your equipment maker already uses this *perfected*, service-tested steel—but it pays to be sure.

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USS

U·S·S STAINLESS STEEL

SHEETS · STRIP · PLATES · BARS · BILLETS · PIPE · TUBES · WIRE · SPECIAL SECTIONS

9-381

UNITED STATES STEEL

Control food costs . . . Save time . . . with TOLEDO all the way!

Now—modern Toledo Scales and Food Machines *take the guesswork out of cost control* in your kitchen . . . help you serve tastier foods.

For example . . . the Toledo Steak Machine produces tempting menu items . . . is rapid and simple in operation . . . easy to clean and to keep clean.

Also, a Toledo Saw and Toledo Chopper help save time and avoid waste in preparing meats.

For closer cost control—*weigh it in* . . . check all foods received with Toledo Accuracy! *Weigh it out* . . . serve your portions accurately weighed with a Toledo SPEEDWEIGH Scale. For accurate quality control weigh ingredients going into mixes. Ask your Toledoman for more information—or write for new bulletin 1130. Toledo Scale Company, Toledo 12, Ohio.

Wonderful New Toledo Steaks . . . tempting, tasty, delicious . . . a new item for your menus . . . produced by the Toledo Steak Machine.

TOLEDO SCALES AND FOOD MACHINES

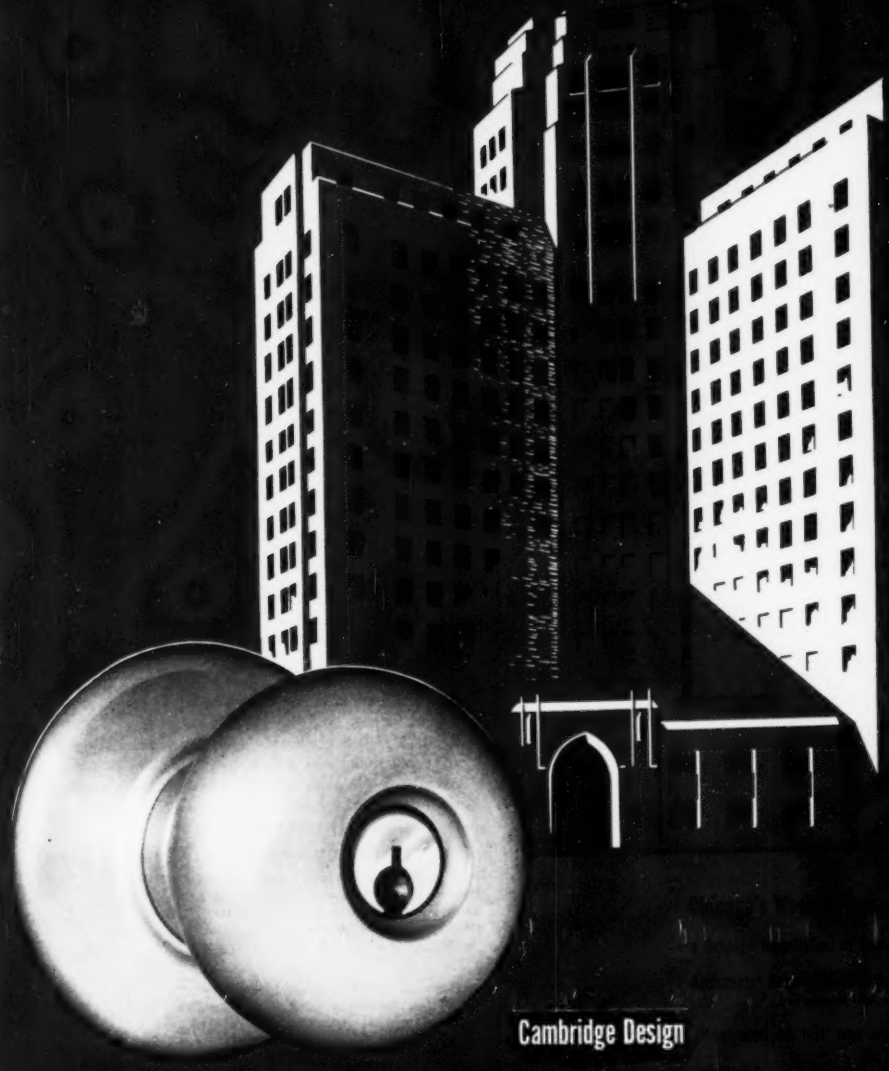
SAWS. New Toledo Saw . . . gives you big capacity . . . new speed and ease in cleaning.

CHOPPERS. New Speed . . . Toledo Chopper . . . gravity feed. Choice of three models to meet your needs.

WEIGH IT IN. Toledo Receiving Scales ideal for weighing-in all produce and meats . . . Portable Scale Model 1800.

WEIGH IT OUT. SPEEDWEIGH over-and-under scales for speedy, accurate weighing of portions.

SCHLAGE



Cambridge Design

SCHLAGE

NOW! UniTrane air conditioning designed especially for hospitals

UniTrane is a new kind of air conditioning that meets to perfection the specialized requirements of big buildings with many small rooms.

It is a unit system. It uses *no* ducts. Yet it supplies better, more comfortable air conditioning than any unit system ever did before.

With UniTrane you enjoy *individual room control* of temperature, moisture, and ventilation. All air is filtered.

No mixture of air between rooms or corridors. Each room has its own year-around air conditioning system, all contained in a compact, unobtrusive cabinet that fits under the window, like a heating unit.

There is no compressor or other complicated apparatus in this UniTrane room unit. The unit is attached to simple piping, such as is used for hot water heating. Circulate hot water in winter; circulate chilled water in summer. It's as simple as that.

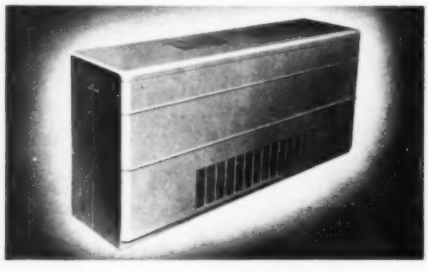
Read "Merely a Matter of Air" for *non-technical* information. Professional data is in Bulletin DS-420.

Ask the Trane sales office in your area about this new kind of individual room air conditioning that controls moisture as well as temperature *without ducts.*

THE TRANE COMPANY . . . LA CROSSE, WIS.

Manufacturing Engineers of Heating, Ventilating and Air Conditioning Equipment—Unit Heaters, Convector-radiators, Heating and Cooling Coils, Fans, Compressors, Air Conditioners, Unit Ventilators, Special Heat Exchange Equipment, Steam and Hot Water Heating Specialties . . . IN CANADA, TRANE COMPANY OF CANADA, LTD., TORONTO.

This Type MC UniTrane Room Unit is beautifully styled for underwindow installation in offices, hotels, hospitals, and other multi-room buildings. Each room has its own temperature, moisture, and ventilation control . . . Data bulletin DS-420 is for architects and engineers . . . "Merely a Matter of Air" is an interesting non-technical discussion of multi-room air conditioning.



WHIZ-OFF and WHIZ WAX

SAVE YOU TIME AND MONEY

...give you better Floor Maintenance and Beauty!

The Whiz Twins make a perfect pair ... go hand in hand in keeping your floors clean, beautiful, safe!

First, Whiz-Off cleans ... powerfully yet safely! Then, Whiz Wax polishes and protects!

They work together, easily, on any floor ... harmless to any surface that is safe with water!

Unbiased tests show that Whiz-Off does a better cleaning job with less work and helps prolong the life of your floors! It is approved by leading flooring manufacturers.

Ask your local Whiz distributor about all the Whiz products designed to help you do a better job at less cost.

R. M. Hollingshead Corporation, Camden, New Jersey; Toronto, Canada. Warehouses: Dallas, San Francisco, Chicago.

The Whiz Twins are backed by the complete Whiz line which includes: **Floor cleaners and waxes; Special cleaners; Disinfectants; Hand soaps and scrubbing soaps; Metal and furniture polishes.**

Whiz

PRODUCTS OF

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LEADER IN MAINTENANCE CHEMICALS

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AUTOMATIC ICE MAKER

Do you use more than $2 worth of cube ice per day? Then a York Automatic Ice Maker can cut your ice costs to a fraction of what they are now.

Turn it on and forget it. It's absolutely automatic . . . freezes and delivers as many as 8000 cubes a day. Finest refrigerating mechanism . . . York Hermetic Unit (completely sealed).

ADVANTAGES OF THE "CUBE WITH THE HOLE"

- Costs far less
- Pure as the water you drink
- Contains no bubbles . . . crystal-clear
- Cools faster
- Won't clump
- Plentiful supply at all times

York

FLAKICE *Frosty* ICE *Ribbons*

Use over 500 lbs. of crushed ice daily? Take a look . . . just flip the switch and watch the frosty ribbons come . . . up to a ton a day . . . Compact unit—can be placed near where ice is to be used.

ADVANTAGES OF FLAKICE FROSTY RIBBONS

- No cheaper ice
- Cools faster
- Scientifically made
- Won't pack
- Less shrinkage
- Sanitary

York *Refrigeration and Air Conditioning*

FROZEN FOOD CABINETS

For commercial establishments, homes, hospitals, restaurants and institutions.

SAVE UP TO 60%*

in your ICE COSTS!

Thousands of places today are making their own ice—in cube and ribbon form—at amazing savings. Compact, sturdy York FlakIce Machines and Automatic Ice Makers give them their own independent supply of ice... right at point of use... with always plenty of ice on hand... night and day!

and here's how to prove you profit before you buy!

1. Call your nearest York Distributor or Dealer, or clip the attached coupon and mail today. You'll get a . . .

2. . . . FREE ANALYSIS of your present ice costs and a positive, practical demonstration of the amazing economies possible with the York Automatic Ice Maker and the York FlakIce Machine.

Here's What They Say . . .

"We are going to pay for our York Automatic Ice Maker in 12 months from savings."

American Legion, Atlanta, Ga.

"By actual comparison with our former ice bills, cubes now cost about 60% less."

Taunton Inn, Taunton, Mass.

"We have tested various types of ice for hospital use and found FlakIce to be vastly superior. It is excellent for ice packs and for ice therapy."

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RETURN FOR FREE ANALYSIS OF ICE COSTS

*Compared with ice cubes costing $1.10 per hundred lbs. Includes maintenance, interest, insurance, taxes and 10% per annum depreciation.

York Corporation
York, Penna.

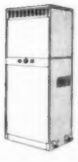
I'd like a FREE ANALYSIS of my ice costs.
I use____lbs. cube ice per day
____lbs. crushed ice per day

Name_____

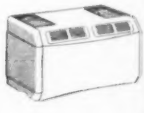
Type of Business_____

Address_____

City_____ Zone____ State_____

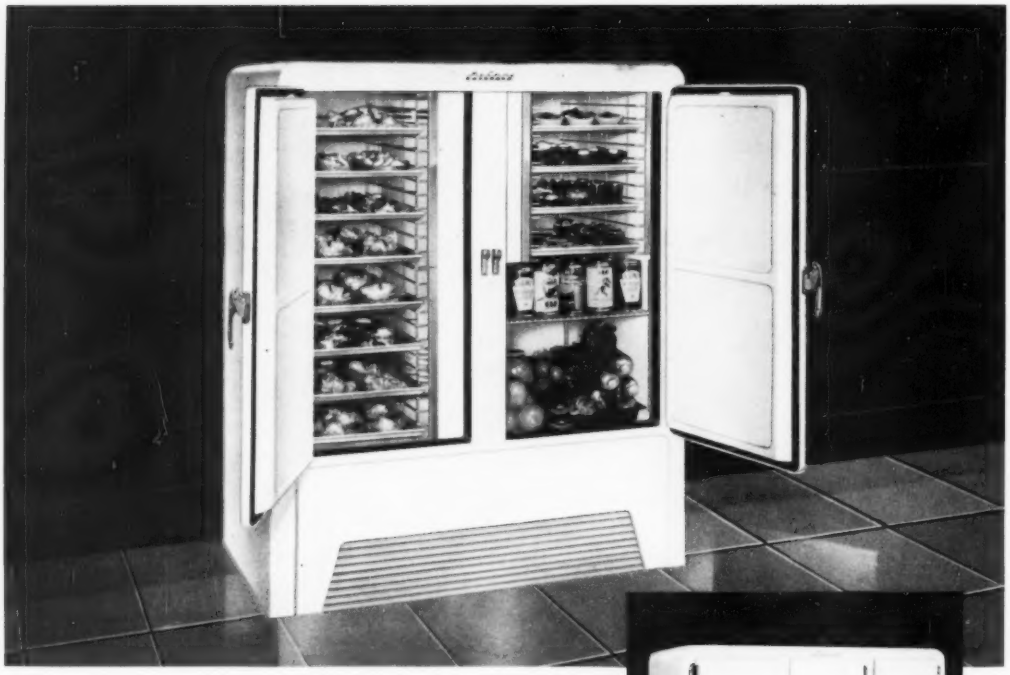


YORKAIRE ROOM CONDITIONERS
Self-contained window units for hospitals, hotels, offices and homes.



YORKAIRE CONDITIONER
Self-contained units for hospitals, stores, restaurants and offices.

Cut overhead costs by organizing your kitchen around new McCray Koldflo Reach-ins!



New McCray Koldflo 40 cu. ft. Reach-in

You can save time and expense by centering all your kitchen activities—meat cutting, salad making and meal assembly—around McCray Koldflo Reach-ins. Everything you need will be at your fingertips. What's more, such dishes as salads and desserts can be prepared long before mealtime . . . and fully protected by famous McCray Koldflo "up-from-under" refrigeration. This permits a perfect balance of temperature, humidity and circulation . . . without direct blasts of cold air. Ask your McCray dealer about the many all-service features.

Full-length solid service doors (as above) or glass doors. All-steel, one-piece construction, ample storage capacity, self contained condensing unit. Sizes include 20, 30, 40 and 60 cu. ft.

THE BEST IN LOW-COST REFRIGERATION

McCray
KOLDFLO

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Color Dynamics

...Pittsburgh's exclusive painting system aids you to use *energy in color* to promote convalescence of patients.

Blue-Green forms an eye-rest focal wall which contrasts effectively with the warm Rose-Tan on side walls and wainscot of this lecture room.

Free ... a COLOR DYNAMICS Plan for your hospital

TO show you how color can be used to improve appearance of your hospital and add to the comfort and well-being of your patients and to the efficiency of medical staffs, we'll be glad to make a COLOR DYNAMICS study of your institution for you on request—free and without obligation on your part.

This new system of painting is based upon the fundamental laws of the *energy in color* and its influence upon human beings. Laboratory tests have proved that color can be used to stimulate or depress, to help people to relax, feel more cheerful.

Working with medical men and physicians, Pittsburgh's color experts and technicians have worked out a new method for using color scientifically and accurately in every hospital department.

By the use of COLOR DYNAMICS, patients' rooms and wards can be given color arrangements that assist convalescence. Purposeful use of color in operating rooms can relieve eye-fatigue and tension of surgeons at their delicate tasks. Graduated steps of receding colors can lessen the feeling of claustrophobia in labor rooms. Proper colors at nurses stations promote alertness and efficiency.

With Pittsburgh COLOR DYNAMICS you can also make offices or living quarters seem more spacious. Rooms can be made to appear longer or wider, ceilings higher or lower, halls wider and lighter.

For a complete analysis of the services COLOR DYNAMICS can perform send for a free, profusely illustrated copy of our book on COLOR DYNAMICS.

Paint RIGHT with COLOR DYNAMICS
Paint BEST with Pittsburgh Paints!

The benefits of COLOR DYNAMICS are made extra long-lasting when you use Pittsburgh high-quality paints. There's a PITTSBURGH PAINT for every need!

WALLHIDE—in three types: **PBX**, extra-durable; **SEMI-GLOSS**, for higher sheen; **FLAT**, for velvet-like finish.

WATERSPAR ENAMEL—for furniture, woodwork and metal trim.

FLORHIDE—for floor surfaces; can be scrubbed repeatedly with soap solutions.

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TEL-O-SEAL CONTAINERS
For I.V. solutions. Permits routine sterility check during storage period. Available in 350, 500, 1000, 1500 and 2000 ml. sizes.

In spite of the current spiral of inflationary costs, your skill plus Fenwal Equipment and Technics can effect drastic reductions in the cost of intravenous solutions for your hospital.

POUR-O-VAC CONTAINERS
For sterile water and saline technics. Available in 350, 500, 1000, 1500, 2000 and 3000 ml. sizes.

FENWAL ASSURES SAFETY, ACCURACY AND CONVENIENCE

1 Standardized equipment and technics which cover every phase of I.V. therapy; sterile water procedure; preparation of antibiotics in solution.

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3 Reusable vacuum closures.

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The Reusable Ampule
Reduces the waste of novocaine and similar medications by permitting periodic withdrawals as required without exposing balance of contents to air. Container and hermetic closure may be repeatedly sterilized. Available in 75 ml. size only.

• *Fenwal representatives are equipped to assist you in the selection, installation and operation of equipment best adapted to meet the volume requirements of your hospital.*

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Specify Rollpruf PIONEER SURGICAL GLOVES

Neoprene Rollprufs now made in hospital green—for easy sorting.

WHEN it's life or death in surgery, no equipment, including gloves, can be too good. Some surgical gloves offer definite advantages your surgeons want but only by *specifying* brand on every order can you make sure of getting them.

By specifying Pioneer *neoprene* Rollprufs, for instance, your surgeons enjoy the nearest thing to bare-hand comfort and working freedom, with finger-tip sensitivity no rubber glove can match — plus safety from the dermatitis-causing allergen in rubber.

All Rollprufs, rubber or neoprene, offer the exclusive advantage of beadless flat-banded wrists, no roll to roll down and annoy at critical moments in surgery. Banded wrists resist tearing, add to the extra-long glove life under frequent sterilizings assured by Pioneer processing.

It pays you to insist on Rollprufs. *Specify* the gloves that help to better surgery — and make your budget go further. Your supplier has or can get them. Or write *The Pioneer Rubber Company, 750 Tiffin Road, Willard, Ohio.*

Pioneer Skin-Finish Rollprufs — made of latex rubber, new skin-soft texture. Non-slip finish on fingers adds remarkable new sureness to surgeon's touch. Flat-banded cuffs — no roll down.

Pioneer Autopsy Gloves—durable comfortable lightweight neoprene gloves. Non-slip finish for greater dexterity. Free of dermatitis-causing allergen found in natural rubber.

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★ The Result of Over 30 Years of Quality Glove Making ★

"Two dozen reasons
for extra happiness!"

Flowers by Wire seem wonderful
for convalescent mothers . . . bring them
extra happiness, rally their spirits,
fill their hearts.

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Flower handling has been made much easier. It's S.O.P. that almost all our 8,000 F.T.D. members deliver flowers *already placed* in containers. These containers are *already filled* with chemically treated water that lasts as long as the flowers.

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It's **new**

Announcing

ANTISEPTIC SEPTISOL Containing G-11

The Most Significant Development in the History of Surgical Soaps

ANTISEPTIC SEPTISOL is a concentrated liquid surgical soap containing hexachlorophene, commonly termed G-11 in recent medical literature.

G-11 is Highly Effective in Soap
G-11, the active ingredient of ANTISEPTIC SEPTISOL, has been tested by prominent medical workers and bacteriologists for a *period of more than five years.* The results of these tests show that it is the *only* known germicide which *is fully effective in combination with soaps.*

Antiseptic Septisol with G-11 is Non-Irritating
Extensive skin tests and prolonged usage *have proven* that G-11 is non-irritating to the skin when used with soap. Specifically, ANTISEPTIC SEPTISOL is the ideal combination of G-11 germicide in a non-irritating soap base.

ANTISEPTIC SEPTISOL GREATLY SIMPLIFIES SURGICAL SCRUB-UP ROUTINE

Saves Time
In SIX MINUTES, less than ⅓ the time required for conventional scrub-up operations, ANTISEPTIC SEPTISOL accomplishes superior bacteriological cleanliness of the skin . . . the reduction of bacteria is almost *one-hundredfold greater* than that achieved by the usual techniques employing ordinary soap followed by germicidal rinses.

Brush Scrubbing is Unnecessary
Laborious scrubbing of the hands and arms with brushes, a frequent cause of skin irritation, is unnecessary with ANTISEPTIC SEPTISOL.

Eliminates Need for Other Antiseptic Rinses
No other antiseptics are required if ANTISEPTIC SEPTISOL is used. Alcohol and Iodine rinses which defat and irritate the skin can be eliminated.

Residual Protection
An invisible bacteriostatic film accumulates on the skin with the repeated use of ANTISEPTIC SEPTISOL. The bacterial population of the skin is maintained at extremely low levels even after suspension of use for as long as two days.

Skin bacteria have been found to multiply under surgical gloves after ordinary soap scrubs. When ANTISEPTIC SEPTISOL is used, the reverse is true . . . the reduction in bacteria continues after gloves are applied.

Other Uses...

ANTISEPTIC SEPTISOL, because of its marked antiseptic value, has many recommended uses . . .

- For routine and preoperative use on patients.
- For the cleansing of traumatic wounds.
- For the various uses of soap in obstetrics and gynecology.
- As an aid in the prevention of pyogenic skin infections.
- For the routine use of nurses, ward attendants, food handlers and other kitchen personnel.

HERE'S YOUR OPPORTUNITY TO LEARN MORE ABOUT ANTISEPTIC SEPTISOL

Attach coupon to your letterhead for easy identification

VESTAL INC. ST. LOUIS NEW YORK

Mail Coupon Today! MH—

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☐ Please send a free copy of your Booklet, ANTISEPTIC SEPTISOL, including the medical research data on G-11.

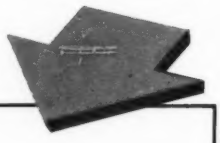
☐ Please quote prices for ANTISEPTIC SEPTISOL.

☐ Please mail a FREE sample of the new ANTISEPTIC SEPTISOL.

Name_____

Title_____

AMERICAN Equipped the



PROBLEM In planning this important new hospital, the need for an efficient, mass-production laundry department was apparent. Equipment must produce adequate supply of sterile-clean linens and uniforms.

SOLUTION Our Laundry Advisor was called in. He carefully analyzed anticipated laundering requirements and problems. Then he submitted complete recommendations, specifications and suggested layout for a modern, efficient laundry. Latest, labor-saving, cost-reducing equipment was installed when hospital building was ready.

RESULTS New laundry meets every requirement of the hospital. All departments have abundant supply of sterile-clean linens for any emergency. Patients and staff appreciate the fine quality laundering. Fast, labor-saving machines hold laundering costs to the very minimum.

Hospitals, *large* or *small*, are invited to discuss their laundry problems with our Laundry Advisor. There is no obligation. WRITE TODAY.

Your hospital will benefit by selecting from American's complete line of the most advanced and productive hospital laundry equipment.

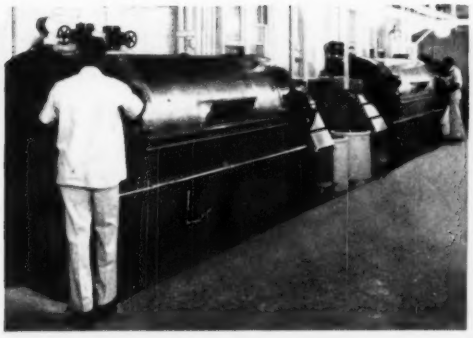
Battery of ZONE-AIR Tumblers for fluff drying towels and other unironed pieces.

Uniforms and wearing apparel for staff and patients are completely machine-ironed on these 3 One-Operator Press Units.

THE AMERICAN LAUNDRY MACHINERY

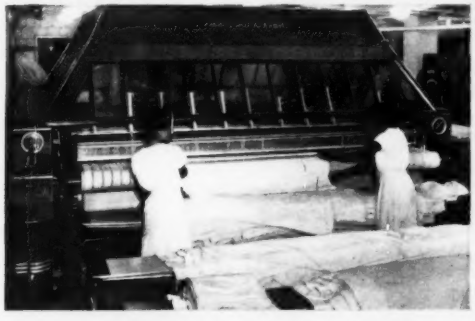
Laundry Department at 405-Bed George Washington University Hospital,

WASHINGTON, D. C.



● Two CASCADE Automatic Unloading Washers with Companion Washing Controls save more than 50 manual operations each load by performing all washing operations automatically. Washers are unloaded by pressing buttons.

So easy a girl can do it. Loaded Containers are hoisted into and out of NOTRUX Extractor by push-button-operated electric hoist.



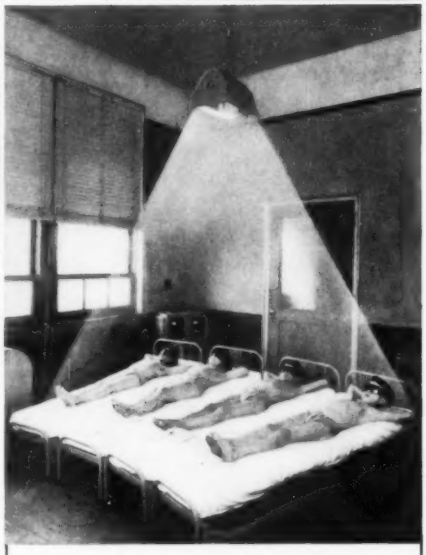
● Flatwork is beautifully ironed at high speed on 8-Roll SYLON Ironer with Airvent Canopy.

Remember . . .

Every Department of the Hospital Depends on the Laundry.

COMPANY CINCINNATI 12, OHIO

HANOVIA'S *HIGH INTENSITY* ULTRAVIOLET QUARTZ LAMPS for group irradiation



Effective, economical and always available for hospital service, this remarkable Hanovia Lamp makes it possible to irradiate as many as six patients at one time.

This cuts down personnel, reduces cost of service, permits more efficient work in Ultraviolet therapy and effects a substantial saving.

Many hundreds of dollars can be saved annually by this group lamp. One technician can treat a large number of patients every day.

A Partial Range of Clinical Usefulness

TUBERCULOSIS With Ultraviolet exposures and hygienic treatment, the symptoms referable to the intestinal tract generally vanish during the first few months of irradiation.
The mercury quartz light is often preferred when pulmonary disease is exudative and febrile, because of its great dificiency in heat rays. Better results are then had in tuberculosis of the intestine, peritoneum, epididymis and lymph nodes. Benefits are had by patients suffering from tuberculosis of the bones, articulations, peritoneum, intestine, lymph nodes and larynx when the entire body is exposed to light rays. In tuberculosis of the skin, lupus vulgaris alone can be said to respond satisfactorily to Ultraviolet irradiation.

INDOLENT WOUNDS In certain cases of indolent ulcers and wounds, occasional erythema doses of Ultraviolet radiation or daily treatment with graduated doses of Ultraviolet Rays seem to be helpful. Some indolent ulcers and wounds appear to respond rapidly and favorably.

ERYSIPELAS Good results have been obtained in erysipelas with both X-rays and Ultraviolet Rays. Recently many reports have appeared in literature which show that Ultraviolet radiation is a safe and successful method for the treatment of erysipelas, especially in the very young and the old.

CUTANEOUS DISORDERS There have been numerous reports of good results with general body irradiation with Ultraviolet Rays in cases of dermatitis herpetiformis and chronic pemphigus. Ultraviolet radiation has been found useful for shortening the course of pityriasis rosea.

MISCELLANEOUS CONDITIONS In selected forms of general debility, secondary anemia, in convalescence after operations and infectious diseases, in chronic bronchitis and sensitiveness to acute respiratory disorders, in bronchial asthma, in selected forms of neurasthenia, light therapy has proved a valuable adjunct to general medical treatment.

HANOVIA ONE BURNER GROUP SOLARIUM LAMP
MODEL NO. 2137

covers an area of 144 square feet, casting no shadows.

Designed to project the light at a downward angle and, combined with direct irradiation, gives an even spread of radiation over the entire length of four to six beds. This model may be employed in multiples. Special layouts furnished upon request. Address Dept. 315-B

HANOVIA CHEMICAL & MFG. CO.
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WORLD'S OLDEST AND LARGEST MAKERS OF ULTRAVIOLET LAMPS FOR THE MEDICAL PROFESSION.

Small Hospital Questions

Conducted by Jewell W. Thrasher, R.N., Frazier-Ellis Hospital, Dothan, Ala.; William B. Sweeney, Windham Community Memorial Hospital, Willimantic, Conn.; A. A. Aita, San Antonio Community Hospital, Upland, Calif.; Pearl Fisher, Thayer Hospital, Waterville, Maine, and others.

Costs Too Much

Question: We serve about sixty persons at each meal. Recently, in my absence, the following was ordered to be used for Friday night suppers. One case 48/1 "Lilly Red Alaska Salmon"—cost $32.50. This seems rather expensive and I should appreciate your opinion.—E.I.B., Mich.

ANSWER: I agree with your subscriber that one case 48/1 salmon is a large amount of fish for serving sixty persons. Four-fifths can per person is a large portion and the per serving cost of $0.541 is larger than the per meal cost in many institutions.—ELIZABETH H. TUFT.

Employment Tests

Question: Are there any aptitude tests that might aid the hospital in selecting domestic employes as well as nurse's aides and nursing attendants?—A.G.E., Me.

ANSWER: Aptitude tests are now used routinely by many industries in selecting employes, and such tests are beginning to gain acceptance in the hospital field, although they are not very widely used by hospitals as yet. Aptitude tests are also used to some extent for promoting employes and transferring them within the organization, inasmuch as skill in one job does not always imply skill in another.

The chances are that some member of your board of trustees or some local industry is acquainted with an industrial personnel expert who can advise you about such tests and how they might be used in the hospital. An excellent article on this subject appeared in the October 1948 issue of The MODERN HOSPITAL ("Employment Tests," by D. H. Radler).

Cutting Down on Paper Work

Question: What is a good way of requesting laboratory tests and recording the results on patients' charts without excessive writing? —O.B., N.Y.

ANSWER: Many hospitals have developed excellent laboratory forms which can be pasted into the patient's medical record without taking up a lot of space; at the same time they keep the recording job to a minimum. The question of the proper way to work laboratory tests should be checked in the individual hospital and an agreement should be reached by the staff doctors, the laboratories, administration and the nursing department as to the best procedure and form to be used. —E. W. JONES.

Manual of Accounting

Question: Please tell me where I may obtain the standard manual for hospital accounting as approved by the American Hospital Association, recently referred to in "Small Hospital Questions." If the manual does not contain the charts of accounts, please add the information as to where I may obtain these.—L.P., Mo.

ANSWER: If your hospital is a member of the American Hospital Association, you should have in your files the standard manual on accounting and statistics which was supplied some time ago by the American Hospital Association to all its member hospitals. If you do not have this manual, you can purchase one by writing to the American Hospital Association, 18 East Division Street, Chicago.

Small Hospital Pay Roll

Question: Can you give us any information on the number of employes and amount of pay roll in small hospitals?—N.C.T., Ida.

ANSWER: The accompanying tabulated information on number of employes and annual pay rolls in small hospitals was compiled by Dr. Louis Block, acting chief, Office of Hospital Services, Division of Hospital Facilities, U.S. Public Health Service, Washington, D.C., from data included in the 1948 "Directory of the American Hospital Association."

AVERAGE PAY ROLL FIGURES

	Number of Hospitals	Per Cent of Occupancy	No. of Personnel per Patient	Av. Annual Pay per Employe
NONPROFIT:				
Under 50 beds.....	805	65.6	1.17	$1,645
50- 99 beds.....	711	75.2	1.31	1,484
100-249 beds.....	842	81.3	1.57	1,429
250 plus beds.....	283	82.2	1.81	1,387
Total.....	2641	79.4	1.61	1,429
PROPRIETARY:				
Under 50 beds.....	863	60.5	1.29	$1,571
50- 99 beds.....	149	69.7	1.37	1,432
100-249 beds.....	55	77.8	1.56	1,498
250 plus beds.....	3	94.1	1.30	1,712
Total.....	1070	67.0	1.39	1,520
GOVERNMENTAL:				
Under 50 beds.....	299	60.4	1.09	$1,730
50- 99 beds.....	206	62.8	1.25	1,388
100-249 beds.....	144	68.1	1.25	1,753
250 plus beds.....	115	74.0	1.30	1,351
Total.....	764	70.2	1.26	1,438
TOTAL:				
Under 50 beds.....	1967	62.8	1.20	$1,627
50- 99 beds.....	1066	72.1	1.30	1,462
100-249 beds.....	1041	79.4	1.54	1,462
250 plus beds.....	401	80.5	1.74	1,377
Total.....	4475	76.9	1.51	1,437

ARMSTRONG X-4 PORTABLE BABY INCUBATOR

1. Low cost
2. Underwriter approved
3. Simple to operate
4. Only 1 control dial
5. Safe, low-cost, heat
6. Easy to clean
7. Quiet and easy to move
8. Ball-bearing, soft rubber casters
9. Fireproof construction
10. Excellent oxygen tent
11. Welded steel construction
12. 3-ply safety glass
13. Full length view of baby
14. Simple outside oxygen connection
15. Night light over control
16. Both F. and C. thermometer scales
17. Safe locking ventilator
18. Low operating cost
19. Automatic control
20. No special service parts
21. Lid locks open

The Armstrong X-4 Baby Incubator is the only Baby Incubator tested and approved by Underwriters' Laboratories for use with oxygen.

The Armstrong X-4 Portable Baby Incubator is a SAFE Baby Incubator, a LOW COST Baby Incubator and a SIMPLE Baby Incubator. That its practical, common-sense design has a wide acceptance is evidenced by the fact that almost 700 hospitals have placed repeat orders for more than 2500 X-4 Incubators. More and more it is being used, not only for the premature baby, but for any underweight or debilitated baby and in the delivery room for every new-born.

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Looking Forward

Nobody Listening Speaker

IT'S BEEN several months since our friend Anastasia attended a hospital convention, and these notes of hers may be a little cold. Come to think of it, however, notes from one convention look pretty much like notes from another. "Wish people who can't get meetings on time would stay away," Anastasia scribbled here, for example. "Traffic this room like department store week before Xmas." Might have been written any convention *we* ever went to.

"Suggest lock doors when meeting starts, open couple minutes between speakers," Anastasia added. "Only other solution armed guard, orders shoot wanderers on sight."

"Everybody here in huddle with neighbor," says another fragment. "Nobody listening speaker. Is this hospital meeting or football practice?"

"Wonder if personality boys who take pride speaking without paper or notes any idea how often they repeat selves?" Anastasia asks. "E.g. this joker, circling past same point third time. Undoubtedly considers self incisive speaker."

"Here comes convention courier," says a final note. "Tiptoed entrance, whispered conference with chairman, tiptoed exit, worried look. Pain in neck (mine). Distracts everybody's attention. Makes speaker wish he were back home Illinois. Not bad idea at that."

No Saving

ASKED to resolve a celebrated controversy that had been raging in the courts for forty-six weeks, Lord Pantagruel ignored the mountains of records, briefs and documents thrust upon him by counsel for the litigants. "Are the two principals in this case still living?" he asked.

"Certainly, My Lord."

"Then what the devil is the use of all this scribblescrabble foolscap?" Pantagruel demanded. "Wouldn't it be better to hear their variance face to face from their own lips instead of all this flapdoodle monkeywriting?"

In Rabelais' hilarious satire, Lord Pantagruel arrives at an immediate judgment. Our own efforts to bring disputants face to face and hear their variance from their own lips did not bring about an immediate solution of the hospitals *vs.* specialists controversy, though we believe it does illuminate the specialists' point of view—a result that may give hospital people a better understanding of these problems.

Certainly there has been an abundance of flapdoodle monkeywriting, some of it ours, on this subject, and we are satisfied that the face to face method is a better one. It doesn't save any scribblescrabble foolscap, though, as readers of the Round Table on the hospital-specialist puzzle, in this issue, will find out. It starts on page 43.

Aid for Nursing Education

FOR several years now, public relations and efficiency experts have been disappearing into the nursing profession, many of them never to be heard of again, a few emerging, after months or years, bearing scars that look like organization charts. It was one of these hardy survivors who remarked that if unification of nursing organizations could be accomplished, world government should be a cinch.

Under the circumstances, it seems likely that most nursing problems will remain endlessly under discussion in joint committees unless some unifying force can be applied from outside the profession. In the opinion of many observers, a force that might accomplish the impossible in nursing is federal aid. After all, it is pointed out, didn't federal aid get hospitals to plan

according to area rather than individual needs? How tough can a problem get?

For one thing, aid to nursing education might offer a method of relieving the nurse shortage without recourse to shotgun recruitment, which fills good and bad schools indiscriminately and thus perpetuates as many problems as it solves. By qualifying schools for financial aid according to their standing as determined by a strong, central accreditation authority, a federal nursing act could strengthen and enlarge an adequate number of university schools, selected by region as well as merit, and ensure the supply of top grade nurse administrators, teachers, highly skilled professional bedside nurses and nurse specialists. The best existing hospital schools could also be aided; others might be converted to training the practical nurses who are needed in such large numbers.

Under such an aid program, too, practical nurse courses could be established in cooperation with public school authorities in areas where no such opportunity exists today. Among other advantages, this plan could be used to encourage the recruitment of much larger numbers of Negro girls into the nursing services. Of course, federal aid wouldn't make it any easier for nursing and hospital groups to determine how many of which kind of nurses are needed. On this point, however, it might be argued that even a wrong decision would be better than none at all.

The big federal hospital systems are staffed today with nurses trained in voluntary hospital schools; federal support for these schools would thus tend to correct a situation under which private resources are subsidizing tax-supported institutions. Under the cooperative program that is contemplated, voluntary nursing schools would be encouraged to use the rich mine of clinical material that is available in near-by federal, state and county hospitals.

Any federal nursing law ultimately should channel aid through state authorities on a matching fund basis similar to that established under Public Law 725. In this way, it is now plain, most of the dreaded evils of federal interference or control can be avoided. However, lack of uniformity among nursing agencies in the various states would mean delay and confusion in effecting such a law today. For the time being, allocation of funds directly to schools, as it was done under the Bolton Act in wartime, would seem to offer a way to get the program started. Some nurse and hospital executives will protest, to be sure, but there is an easy method by which proponents of federal aid for nursing can dispose of objectors so that they will never be heard from again.

Put them on joint committees.

Hospital Hotfoot

THE other day a salesman we know called on a hospital. The information clerk looked him over coolly when he stated his business, then told him to "Go in there." As it turned out, "there" was a barren cubbyhole furnished with a single weather-beaten chair and separated from the general office by a partition that went half way to the ceiling.

After a considerable period, a voice from the other side of the partition demanded, "Well, what do *you* want?" Realizing at length that the voice was addressing him, our salesman explained his connection and asked to see the administrator.

"She can't possibly see you," said the voice. "She's too busy." Our man then asked if he could make an appointment to see the administrator—a mission that was grudgingly performed by the voice. Eventually, the appointment was arranged and the interview came off. They got along fine, and the salesman left with an order.

He also left with a dim view of the hospital that can't be bought off with brochures, posters or press releases. When somebody gets burned like that in a hospital, all hospitals get burned.

Thought for Building Committees

WHICH of you, intending to build a tower, sitteth not down first and counteth the cost, whether he have sufficient to finish it? Lest haply, after he hath laid the foundation and is not able to finish it, all that behold it begin to mock him saying, This man began to build and was not able to finish.

—ST. LUKE: 14:28-30.

Hail and Get Busy!

PRESIDENT TRUMAN'S recommendation that the Veterans Administration hospital construction program be cut down to avoid dangerous overbuilding is heartening evidence that righteousness can make a showing against political pressure, even in these fleabitten times. For vigorously exposing the unpopular truth and carrying the attack forward under heavy pressure, the American Hospital Association and especially its former president, Graham Davis, deserve the admiration and gratitude of the nation's voluntary hospitals.

The greater part of this fight, however, still lies ahead. When Congress comes to consider V.A. appropriations and the possible revision of laws governing eligibility of veterans for medical and hospital benefits, the American Legion and other groups interested in expanding the V.A. hospital empire will begin to apply the kind of pressure that makes legislators, so help us all, think one way and vote another. When this happens, hospital leadership, however powerful and courageous, will not prevail without strong support down the line.

Hospital administrators and trustees should act now to let their representatives in Congress know that the veterans' job can be done better, and for less money, by using more community hospitals and fewer bricks. Whenever possible, the facts should be made known to local Legion and other civic groups, and to the public, with the strong request that every influence be brought to bear on the side of the American Hospital Association, the Hoover Commission and common sense. The President's message indicates that righteousness has won a skirmish, but it won't win the battle without votes.

In the hospital-specialist puzzle—

WHO'S EXPLOITING WHOM?

A MODERN HOSPITAL ROUND TABLE

THE complicated professional and fiscal relationship between hospitals and certain medical specialists, such as radiologists and pathologists, has increasingly occupied the attention of medical and hospital authorities in recent months. Many of these physicians believe hospitals are trying to dominate or control the practice of their specialties, if not all of medicine; the specialists in turn have been accused of restrictive and monopolistic practices.

To get at the truth behind such allegations, The MODERN HOSPITAL invited a group of experts to its editorial offices in Chicago a few weeks ago to discuss these and related problems. Taking part in the discussion were: Dr. W. Edward Chamberlain, professor of radiology at Temple University, Philadelphia, and director of the department of radiology at the University Hospital; Dr. David A. Wood, associate professor of pathology at Stanford University and pathologist at Stanford University Hospitals, San Francisco; Emanuel Hayt of New York, lecturer in hospital law at Columbia University and author of several textbooks on legal problems of hospitals, and Dr. David Littauer, administrator of the Menorah Hospital of Kansas City, Mo. Robert M. Cunningham Jr., managing editor of The MODERN HOSPITAL, also participated.

So that our readers could sit in on the discussion, we had a stenographer in the room taking down everything that was said. In the following pages, The MODERN HOSPITAL presents a transcript of the discussion, condensed somewhat to eliminate repetition and irrelevancies.—THE EDITORS.

MR. CUNNINGHAM: Our purpose here is to shed light on a subject that all of us are interested in, rather than to solve problems. I don't think we are going to solve anything. Maybe there is no solution for the problems that we are going to discuss. I think our chief interest in these problems is in the moral and professional principles involved in them, rather than only the detail, and I hope our discussion will dig into some of those principles.

We see in the medical journals from time to time today the statement that doctors and the medical profession have more to fear from hospitals than from government. Dr. Chamberlain, do you want to take that and tell us what you think of it? What does it mean? Do you agree with it? Is it right or wrong? Why?

DR. CHAMBERLAIN: Well, I think it is only fair to say that ideas like that don't just come out of thin air. They come from circumstances, and there are some very disquieting circumstances that make some doctors feel afraid of the tendency which management has to manage.

I think it is hard to discuss this on the basis of right or wrong. I don't think we get very far saying that it is wrong for hospital management to do

DR. DAVID LITTAUER *has been administrator of the Menorah Hospital, Kansas City, Mo., since early in 1946, when he was discharged from the army medical corps with the rank of colonel. A graduate of New York University Medical School, Dr. Littauer served residencies in New York City and practiced medicine there for several years before the war. He entered the army as a first-lieutenant and served successively as head of a school for medical department technicians, staff surgeon in the Air-Borne Command, executive officer in the medical section of the Fourth Army, and commanding officer of the 86th Evacuation Hospital. Since entering the administrative field in civilian life, Dr. Littauer has been active in local, state and national hospital councils and associations.*

DR. W. EDWARD CHAMBERLAIN *is director of the department of radiology at Temple University Hospital, Philadelphia, and professor of radiology at the university medical school, where he has been a member of the staff for the last twenty years. Prior to that time he held similar positions at Stanford University Hospitals, San Francisco. Dr. Chamberlain is a graduate of the University of California Medical School, a fellow of the American College of Physicians, and a diplomate of the American Board of Radiology. Dr. Chamberlain is also a consultant in radiology to the Public Health Service and the National Research Council. He has been chairman of the board of chancellors of the American College of Radiology and winner of the College Gold Medal Award.*

the things that they have done. There is just as much wrong on the side of the doctor who allows himself to be handled in a way in which I personally won't allow myself to be handled, and I'd rather see it discussed on that basis.

Now, I think doctors have a good deal to fear from hospital management when you consider some of the things that have happened to doctors because of hospital management. So many men in my particular specialty have worked hard, have done a good job and done exactly what they were supposed to be doing, and have built up a practice, and have then been told by management: "Well, Doctor, the agreement under which you have been practicing here was all very well back in the days when the hospital was losing money and you were making $7000 or $8000 or $12000 a year, but now that your income has reached the point where it is now, we'll have to renegotiate your arrangement and see to it that you don't make quite that much money."

Now, that sort of thing frightens me, insofar as doctors are involved in hospital practice and get themselves into the relationship that many radiologists and many pathologists have to hospitals, and that some surgeons and obstetricians are beginning to have to hospitals. We doctors would like to know how safe our future is in the hands of hospital administrators.

DR. LITTAUER: May I ask whether the situation you refer to about renegotiation of contracts downward—is that the rule or the exception in your experience?

DR. CHAMBERLAIN: It is the rule.

DR. LITTAUER: The rule?

DR. CHAMBERLAIN: Definitely. In fact, I can document it one time after another. The arrangement was perfectly satisfactory at a time when the hospital was losing money, but the radiologist was making very little. Then, when the income of the radiologist grew, as it is bound to grow when good work is done, the situation was no longer acceptable to management.

DR. LITTAUER: Wouldn't you say that a good part of that is based upon the fact that the hospital practice of radiology has changed, as many other activities have changed? For example, the capital investment in a department of radiology is considerably greater now than it was, say, twenty years ago. The income from the department is also considerably greater. The hospital is there to serve the community. I don't think either hospital administrators as a group, or hospital trustees, have any desire to exploit any of the specialists, the radiologist, the pathologist, or others. There is no question, however, but what the type of work which can be done in a department of radiology or a department of laboratories has changed considerably and that the sources of income are somewhat different.

DR. CHAMBERLAIN: Well, of course, Dr. Littauer, you and I look at these things from such an absolutely opposite direction that your language is almost beyond my understanding. I mean when you speak as you do about the fact that hospital management and hospital boards of trustees are more or less the people who are looking out for the public welfare, that suggests that the radiologists and other doctors aren't interested in the public welfare. Now, actually, in my—

DR. LITTAUER: No, it doesn't suggest that.

EMANUEL HAYT *is a lecturer in hospital law in the hospital administration course, school of public health, Columbia University, New York, and special lecturer in hospital administration at the University of Minnesota. He is also counsel to the Greater New York Hospital Association. Mr. Hayt was born in New York City and attended New York University, the College of the City of New York, and the Brooklyn Law School of St. Lawrence University. He was admitted to the New York Bar in 1929 and has been associated since then in partnership with his wife, Lillian R. Hayt. With Mrs. Hayt, he is author of three books on hospital law: "Legal Aspects of Hospital Practices," "Legal Guide for American Hospitals," and "Law of Hospital, Physician and Patient."*

DR. DAVID A. WOOD *is pathologist at Stanford University Hospitals, San Francisco, consulting pathologist at a number of affiliated hospitals, and associate professor of pathology on the university's medical school faculty. With the exception of the years he spent as chief of pathological services at U.S. Naval Hospitals during World War II, Dr. Wood has been a member of the staff of Stanford University Medical School since his graduation in 1930. He is also a consultant in pathology to the Veterans Administration, a director of the American Cancer Society, a member of the executive committee of the California Society of Pathologists, and a member of the special committee on hospital and institutional relations of the College of American Pathologists.*

DR. CHAMBERLAIN: Well, put it this way: I don't happen to know of one single case in which less money was made from the practice of radiology after the hospital took over certain prerogatives that had formerly been the prerogatives of the radiologist. In other words, we are talking about whether a radiologist shall be permitted or shall find it possible to build himself a future with security in it as he used to be able to do. When a group of men like radiologists find that as a result of these changes that you are talking about, their security has been taken away from them in large measure, they would be very peculiar human beings if they didn't begin to take cognizance of the fact. They look around and say, "How did we get into this fix?" And they see that one of the ways they got into this fix is through the natural desire of hospital management to take over some things which used to be the prerogatives of the doctors.

MR. CUNNINGHAM: What things?

DR. CHAMBERLAIN: A doctor friend of mine used to be the superintendent of his hospital as well as the radiologist, because there wasn't enough work to do in the radiology department to keep him busy all the time. While he was the superintendent, I joshingly said to him, "Look here, why doesn't Jones the superintendent give Jones the radiologist the kind of basis that you and I really think the radiologist should have—allow the radiologist to collect his own fees instead of having them collected by the hospital? After all, the surgeons in your hospital collect their own fees."

He laughed and said, "Well, I just don't want to complicate my life. I'd rather have the bookkeeper in the business office do it."

"Well," I said, "watch out that some day it doesn't boomerang."

In the course of time he built his radiologic practice up and it required all of his time, and the board of trustees got another hospital administrator. Within a few months the point was brought up, "You are making too much money. We are not willing to have you receive that much income."

On that point he had to leave, and he opened his private office in a nearby office building, and ever since then has made a little bit better living than he made as the radiologist of that hospital. The fact is that a radiologist doesn't have security, because with a change of administration, a new superintendent comes in, or somebody decides that he's making too much money. How much is being made by the surgeons in that same institution doesn't seem to be as yet a matter for the concern of the management, but the radiologist, because his income is a matter of record, is a special target. Now, that's a fix.

MR. CUNNINGHAM: Isn't there another aspect to it in addition to the amount of money that he's making becoming a part of hospital management's scrutiny? That is this: Doesn't the radiologist's situation set itself apart because the hospital makes some contribution, some economic contribution, to his practice? That is, he doesn't have the same relationship to his practice, we'll say, that the family physician or the surgeon or the obstetrician does. Now, does that belong in this discussion?

DR. CHAMBERLAIN: It certainly does. It is always brought up whenever any radiologist is negotiating with the hospital. It is a practical matter.

MR. CUNNINGHAM: What contribution is made by what parties?

DR. CHAMBERLAIN: Of course, some radiologists have solved that very beautifully by having a different arrangement with the hospital for outpatient practice from the arrangement they have for inpatient practice, because it is obvious that outpatients coming in could have gone to a practitioner of radiology in a different place.

My own reaction is this: The radiologist, if he's wise, says, "I'll not allow the hospital to collect my fees any more than the surgeon allows the hospital to collect his fees," and under those circumstances it is perfectly possible to work out an arrangement in which rental or lease payments are made by the radiologist to the hospital for the use of apparatus, for floor space, for depreciation and repairs and upkeep of the apparatus, for whatever part of the pay roll is handled by the hospital, and other expenses.

The amounts payable by the radiologist to the hospital, I suppose, might in some way that I don't just see plainly be enhanced by payments owing to the fact that the doctor is receiving some of his referrals as a result of being that particular hospital's radiologist. I don't know how to work that out, but I should think that a radiologist would be glad to pay higher rental if he is going to have some work referred to him. Often, of course, the extra practice is merely an added expense to the radiologist, because he has to take on other radiologists to help him in order to handle the increased volume of work.

MR. HAYT: I think the difficulty arises from the fact that the radiologists, as well as other specialists, such as the pathologists and the anesthesiologists, consider that they have a vested interest in the hospital. By a vested interest I mean that they are either in joint ownership with the hospital or they have some proprietary interest in the institution. The fact is that usually the hospital provides the machinery, which is very expensive. It provides all the technical assistance for the doctor, and it enables him to make money which he would not otherwise make.

DR. CHAMBERLAIN: I deny that, Mr. Hayt. I think that is absolutely untrue.

MR. CUNNINGHAM: Is it always untrue?

DR. CHAMBERLAIN: Well, it happens that I know many instances in which the radiologist has left hospital practice and gone out and opened his own private office, and he invariably has made more money as a private practitioner in an office building than he has made as the radiologist of the hospital, on a salary or a percentage basis.

Now, I happen to be collecting my own fees and paying my own expenses. I pay the technical expenses and material expenses and see to it that the proper number of radiologists are available to handle the practice which comes in my name, but which is bigger than I can handle all by myself, and so if I moved into a private office building, I would make exactly the same amount of money that I make where I am, because the hospital space that I occupy is virtually space in an office building, so far as my economic arrangement is concerned.

DR. LITTAUER: Dr. Chamberlain, how many radiologists, particularly young radiologists, do you know who could afford to purchase the equipment in the average, medium-sized hospital, employ technicians, purchase supplies, and operate a department which would ensure the highest type of radiological diagnosis and treatment which that hospital should give, which the staff demands?

DR. CHAMBERLAIN: Don't you think the hospital ought to own the x-ray equipment?

DR. LITTAUER: I think unavoidably if the hospital owns the x-ray equipment, it has some say in how that equipment should be used and what arrangements for income from the use of the equipment should be made.

DR. CHAMBERLAIN: The hospital owns the operating room equipment, doesn't it?

DR. LITTAUER: Well, let's explore that point a little further. Compare the surgeon to the radiologist. Do you consider that their activities are the same? Are they completely comparable?

DR. CHAMBERLAIN: I think they are much closer to comparable than the hospital world would like to admit.

MR. CUNNINGHAM: How about the patient world? Does the doctor-patient relationship exist in radiology as it does in general practice?

DR. CHAMBERLAIN: Well, of course, it does on the therapeutic side, very much so.

MR. CUNNINGHAM: Which is what per cent of radiology practice?

DR. CHAMBERLAIN: In many hospitals it is about 25 per cent of the total.

DR. LITTAUER: That's just in the large teaching hospitals. In the average, nonteaching hospital in a small city, it may be only 5 per cent.

DR. CHAMBERLAIN: Really? Is that so?

DR. LITTAUER: That's so.

DR. CHAMBERLAIN: Well, in my private office it's been about 25 per cent, and it's been about 25 per cent at Temple, so I didn't realize it was so undeveloped in smaller hospitals. But I'd like to point out the fact that there is no fundamental reason why the hospital shouldn't own the x-ray equipment and at the same time allow the radiologist to pay the expenses and to pay his share of upkeep and replacement and amortization costs and all the other things that should be included.

MR. CUNNINGHAM: Here's a point that I think may have a part in this discussion: When you speak of economic security and of the threat to your security, Dr. Chamberlain, you speak from the point of view of a mature practitioner whose competence and reputation are such that you can stand on your own feet economically. To many people in your specialty who don't command similar security themselves, the salary may represent security.

I have a friend who is a hospital administrator who was up against one of these situations that you are talking about. He was cagey. He sent a form letter out to a few hundred specialists in which he described the situation of the community and the hospital and said that the hospital was thinking of employing a radiologist on a salary and did they know of anyone that they might recommend for the job? The result was astonishing. He had a high percentage of replies, and they all said

pretty much the same two things: "We don't particularly care for the salary arrangement. How much is it?" The salary looked like security to a lot of those people.

DR. CHAMBERLAIN: I think that is true, and that's one reason I have refused to be a party to any attempt to make it impossible for young men to accept salaried positions in the hospital. It is all very well for a man in my position to say, "I will not allow a hospital to collect my fees," but for me to say to a young man who is just getting out, "You can't do this, you have got to insist on the same things that I would insist on personally," I think would be utterly immoral, so I have no part in that at all.

DR. WOOD: Is there anything wrong with a plan whereby the young man would buy the equipment on an amortized basis from the hospital, paying depreciation on it, and then if and when the contract with the hospital is terminated, have the hospital take it back at its depreciated value?

DR. CHAMBERLAIN: I suppose something like that could be arranged. But I have always assumed that if I were a hospital administrator, I would feel very strange if the hospital didn't own the equipment. I try to look at these things—it may not seem to Dr. Littauer that I do—but I really do try to look at these things from the standpoint of the hospital also.

DR. LITTAUER: I am sure you do, Doctor. I can assure you that most hospital administrators try to see the point of view of the specialists, too.

DR. CHAMBERLAIN: I think that is true. I have found it so. I think the equipment should always belong to the hospital, or at least if the radiologist puts equipment in, it should be amortized so that it ultimately belongs to the hospital.

DR. WOOD: All right, then. If the equipment is depreciated on a good, fair basis, doesn't it become more or less academic then as to who actually owns that equipment?

MR. HAYT: I'd like to make some comments on some of the statements that were made. The surgeon does not hire the operating room or rent it. He doesn't pay for the nurses in the operating room, and no surgeon has ever proposed that he would take over the operating room on a rental basis and pay for the assistance he gets in the operating room. The proposition by the radiologist and the other specialists is to take over the operation of the department and pay a rental to the hospital. There is, therefore, a great distinction between the position of the surgeon and his relation to the hospital, and that of the radiologist.

Now, I am wholly in sympathy with the doctor getting security, but I think that the radiologist is in a better position to have economic security than the members of the surgical staff. As you know, members of the attending staff are appointed for one year's tenure, and at the end of the year they can be dropped from the staff without any notice whatever, whereas the radiologist and the anesthesiologist and the pathologist are in the position to enter into a contract of employment, if they so wish, which may extend for five or ten years, at a fixed salary, and it seems to me that the man who is in a position to have a definite salary and a long period of employment has greater security than the surgeon or any other member of the staff.

Many young men do go into the hospital on a salary basis as specialists. They have spent a great deal of time and money in their education, and they are hardly in a position to buy equipment or set themselves up in competition with older practitioners. These young men, who are willing to accept salaries, are in a position to advance themselves, gain further experience, and obtain economic security.

The purchase of equipment by the radiologist is an undesirable arrangement, because it puts him in a position to dictate the amount of the charges for the various services. It also puts him in a position to refuse to do free work for ward patients, and it gives him a preferred position in the community over others who are practicing the same specialty and who have no hospital connections.

It is true in all states that the hospital is given tax exemption as a charitable institution on the basis that it is performing a public service and that no person connected with the institution is getting the benefit of the profits. A nonprofit institution is one in which no part of the income goes to any individual except as reasonable compensation for services actually rendered. If we allow the radiologist to hire the department and make a profit, he is getting the benefit of the exemption of that property and it wasn't intended that any individual would have the benefit of tax exemption, but rather that this charitable institution would get the entire benefit.

Such an arrangement is very likely and has in some cases jeopardized the tax exempt status of the hospital. I had a recent letter from the Association of California Hospitals, in which the executive secretary states that two hospitals forfeited their tax exemption because the radiologists received excessive compensation. I don't think that the problem is an insurmountable one, but certainly there should be security for the patient to the extent that the hospital will have sufficient income to continue with its activities, and there should be security for the specialists to enable them to earn a good living commensurate with their skill, ability and time. It has been said that if the patient is being exploited by high rates for x-rays, the first ones to complain about a reduction in the rate might be the other practitioners in the neighborhood who would say that the hospital is competing with them by charging less than the average price in the community.

DR. CHAMBERLAIN: If you allow me to answer, I will take up too much time. I am enjoying this very much, and everything that is said stimulates me to say something else, but I am just built that way, and that's why Bob Cunningham invited me here.

MR. CUNNINGHAM: That's why you are here, Doctor. Go to it.

DR. CHAMBERLAIN: I want to get back to talking about security. Mr. Hayt speaks of the fact that surgeons customarily are appointed from year to year and can lose their appointment at the end of a year, and theoretically they can. If they are successful, they don't, but if they are successful and they should, they would immediately take their practice with them. Mr. Cunningham suggested a point which I think is foolish not to bring into this discussion, even though it hurts my feelings.

You asked a while ago: Is the private practice relationship, the patient-doctor relationship, the same in radiology as it is in surgery or in medicine, and of course—

MR. CUNNINGHAM: That's what the real security is, isn't it?

DR. CHAMBERLAIN: Of course it is. That's exactly right.

MR. CUNNINGHAM: The man's security is his professional competence, not his compensation.

DR. CHAMBERLAIN: Exactly. Now you have put your finger on it; we shouldn't have deviated from that. I wanted to come back to it, because

even though in a sense it is a point against my wishes and desires, it is a fact that has to be faced.

Here is the thing: The surgeon enjoys a certain security because people care very much who does their surgery. People don't just say, "All right, if I'm to be operated on, the hospital can choose my surgeon, or somebody else can choose my surgeon." No, they say, "Who is this fellow?" and "Am I willing to have him operate on me?"

Well, they also care who does their internal medicine. They don't have a man as their private doctor or as their obstetrician except one that they have confidence in themselves. Well, now, the fact of the matter is that the average patient doesn't give a darn who does his radiology.

MR. CUNNINGHAM: Never finds out his name, in many cases.

DR. LITTAUER: Dr. Chamberlain, the surgeon and the internists have that kind of security?

DR. CHAMBERLAIN: That's right.

DR. LITTAUER: Because the patient knows them?

DR. CHAMBERLAIN: That's right.

DR. LITTAUER: But the radiologist, the pathologist and the other specialists have another type of security. In most hospitals which do not have closed staffs, any qualified surgeon or internist can usually sooner or later get on the staff of the hospital, admit patients, use the operating room, and so forth. Now, suppose a qualified young radiologist came to Philadelphia and wanted to use the facilities of your radiological department. Suppose he came to your laboratories, Dr. Wood, and he was a qualified pathologist and director of laboratories, and he wanted to use it for his patients. Could he use the x-ray department and the laboratories of your hospitals?

DR. WOOD: He could in my institution. I'd welcome that.

DR. LITTAUER: Could he charge for it? I mean, could he set himself up in your hospital, in the private practice of pathology, and in your hospital, Dr. Chamberlain, in the private practice of radiology?

DR. CHAMBERLAIN: Well, the funny thing about that is the reason he can't in my hospital is that the management isn't willing. I tried very hard to get that established as a principle. I don't like this talk about monopoly. I think it is a lot of foolishness.

DR. LITTAUER: But when you have a contract, you must have a monopoly. The hospital assumes an obligation to the specialist and cannot permit someone else to come in. Now that is a form of security also—

DR. CHAMBERLAIN: Is it?

DR. LITTAUER: —of a different type than the physician-patient relationship, but it is a definite form of security. Now, suppose the volume of work of a department increases, and it is possible because of the increased income which goes with the increased volume to think about reducing charges so that the public may benefit. The principal source of opposition lies with the specialist himself.

DR. CHAMBERLAIN: Are you sure about that, Dr. Littauer? In my experience the smallest hospital in the city, with the most inexperienced radiologist, may call up the other hospitals, like mine, and say, "What do you charge for a G.I.? All right, that's what we are going to charge. We just wanted to know what the current rate is." I invariably think, "There is something funny about radiology, in that the rates are established by the places that do the outstanding work and have the outstanding reputation, and the smaller and lesser people charge the same rate, and I don't know of exceptions."

MR. HAYT: Well, what better security can the radiologists have than to have a monopoly on all the x-ray work in the hospital? No one else in the institution has a monopoly on all the work of one class. Certainly no surgeon does all of the surgical work in the hospital, no urologist does all of the urological work, but the radiologist gets all of the work in the hospital.

DR. CHAMBERLAIN: Well, Mr. Hayt, we would be awfully glad to get rid of the monopoly if we could get just a little bit of security, but the only way we can have security is if we go into an office building. I think that the outstanding men in radiology should all be in hospitals, because I think the radiology that is practiced in hospitals is more important than the radiology that is practiced in private office buildings.

MR. CUNNINGHAM: What are the reasons?

DR. CHAMBERLAIN: Sicker people. People go to the hospital because they are in need of all the facilities. The people who go to the private radiologist in his office building are often people who have a stomach ache that isn't very important.

DR. LITTAUER: Dr. Chamberlain, is there a difference in security on a percentage of the gross and on a salary?

DR. CHAMBERLAIN: Let me go on and finish this little point about the office building. The radiologist who goes into an office building has security because he is building something for himself, and as his reputation grows and his practice grows, he has something that he can keep on and keep as his own, as long as he has sufficient physical stamina to stand up and do his work.

Now, when he goes into a hospital, again and again the hospital management has said to the radiologist, "You are making too much money, and you have got to renegotiate your contract." That has happened so many times that we have lost faith in any contract we may make with the hospital, because our exact income is known to the hospital, where it isn't known to the hospital or anybody else if we are in an office building.

DR. LITTAUER: It frequently happens that the increased income of the radiologist on a percentage arrangement is due to efficiencies in management and has nothing to do—

DR. CHAMBERLAIN: If his income is a percentage of the gross?

DR. LITTAUER: Yes.

DR. CHAMBERLAIN: The gross is based on the number of patients.

DR. LITTAUER: I will give you an example of what I mean. I know of a hospital which, without adding a bed, increased the number of patient admissions in one year by 1000. That was a 20 per cent increase in admissions. That was due to efficiencies effected by the hospital management.

The radiologist spent no more time at the hospital than he did before. He was on a percentage of the gross. His income rose appreciably, because of efficiencies in hospital management, not because he happened to be a very fine radiologist. No one questioned that, but through his own efforts he did nothing to warrant a sudden increase in his income. It was all effected by hospital management. Now—

DR. CHAMBERLAIN: Of course, he did work harder, didn't he?

DR. LITTAUER: He spent no more time at the hospital.

DR. CHAMBERLAIN: He saw more cases. Otherwise the gross income wouldn't have increased.

DR. LITTAUER: The question is whether, because of someone else's efficiency, he should continue to receive

the same percentage as he did before.

DR. CHAMBERLAIN: The whole theory of the 50 per cent of the gross is that that is about the part of the fee that would be retained by the radiologist in a private office.

DR. LITTAUER: In a private office, the income is due to the efforts of the radiologist himself.

DR. CHAMBERLAIN: Now, Mr. Hayt made the point that if we allow the radiologist to make a profit in a tax exempt institution, we jeopardize the tax exempt status of the institution. I am just as insistent as Mr. Hayt is that no doctor on the staff shall charge the free patient.

One of the objections I have to the percentage basis is that it places the radiologist in the unfortunate position of getting something from the free cases, because so-called free cases often pay something and in this very unhappy situation the radiologist is actually—if you look into the bookkeeping—accepting a percentage of the money paid in by free cases, whereas the surgeons and internists in that hospital are doing their work free.

DR. LITTAUER: I don't think that is a major problem.

DR. CHAMBERLAIN: Well now, it may not be a major problem, but Mr. Hayt brought it up and I want to get it into the record that in my institution, where I collect the fees, I collect fees only from private patients. If they pay anything at all, nonprivate patients pay it to the hospital, and of course everyone knows that the hospital doesn't collect as much from those cases as it costs to render the services.

I want to ask Mr. Hayt this: If surgeons can collect their own fees without jeopardizing the tax exempt status of the hospital, why cannot the radiologist collect his own fees without jeopardizing the tax exempt status of the hospital?

MR. HAYT: The answer to that is that there is, in the first place, a personal relationship and a contract between the surgeon and the patient. In the case of the radiologist, there is no contract between the patient and the radiologist. Frequently the patient doesn't even know the name of the radiologist. The surgeon would have to use the property of the hospital in order to operate. If a hospital's exemption were to be revoked on the ground that the surgeon used an operating room, the whole business of tax exemption would be ridiculous. We might as well close the hospital. That is quite different from the radiologist or another specialist actually renting part of the hospital for his own business.

DR. WOOD: The way our revenue and taxation code reads is as follows: "The property is not used or operated by the owner or by any other person for profit, regardless of the purpose for which profit is devoted."

DR. CHAMBERLAIN: If that kind of statute is used to argue the radiologist out of his position of collecting his own fees, it will also have to be used to prevent the surgeon from collecting his own fees.

DR. LITTAUER: Do you submit your own bills?

DR. CHAMBERLAIN: Yes.

DR. LITTAUER: Is that the accepted procedure, or do not many radiologists take as a matter of course the fact that the charges for x-rays are included in the hospital bills?

DR. CHAMBERLAIN: Well, I don't know the answer to that, Dr. Littauer. I know that, of course, most radiologists have their fees collected by the hospital, that only 15 per cent of the radiologists of the country, I have been told, have the arrangement that I have, of collecting their own fees.

MR. CUNNINGHAM: Do you think it would be desirable if they all had?

DR. CHAMBERLAIN: Oh, yes, I do. I think that hospitals and raliologists would get along famously if we could establish this principle, that the radiologist is much more of a doctor and less of a technician than has been generally supposed; that it is his misfortune that he hasn't got more of a personal relationship to the patient; that he does have a slightly greater patient-doctor relationship when he submits his bill for the services rendered, instead of having his bill included in the hospital bill, and that the tendency will be for the hospitals to have the very best radiologists in the whole land in hospital practice if that sort of a thing were established.

MR. CUNNINGHAM: What becomes of me—I am playing patient now—if I go to Dr. Littauer's hospital and I pay my doctor and possibly a clinical consultant and the hospital bill and your bill and Dr. Wood's bill, and an anesthesiologist's bill? I am all fouled up with bills from all directions. Possibly I don't pay any more in the end that way than I would today under the arrangement that exists, but I feel pretty put upon. I mean, this has become a tremendously complicated fiscal experience for me. Is that part of the problem?

DR. CHAMBERLAIN: No question about it.

MR. CUNNINGHAM: What's the answer?

DR. CHAMBERLAIN: The answer is that the radiologist doesn't want to be singled out and treated differently from other practitioners of medicine.

MR. CUNNINGHAM: Is he singled out by the hospital—or by circumstances, by the nature of his practice?

DR. WOOD: Part of the answer is that the radiologist, irrespective of whether he is in the hospital or out of the hospital, is in the nature of a consultant.

MR. CUNNINGHAM: That's right, he is a consultant to the patient's physician, rather than the patient.

DR. WOOD: Therefore, part of the problem comes back to the physician. The patient should be apprised at all times of the consultants that are called to assist in the diagnosis and management of that case.

MR. CUNNINGHAM: Why?

DR. WOOD: These are men who are being brought into the case.

MR. CUNNINGHAM: I am going to Dr. X, my family doctor. He needs help from you, Dr. Wood, and he needs help from Dr. Chamberlain, and he needs help from, we'll say, a surgical consultant. Now, do I get better care if I know who you are, or if I know who Dr. Chamberlain is? Does it make any difference to me? What we are all interested in here is the patient's care.

DR. WOOD: Sometimes you ask for Dr. Chamberlain as a radiologist or Dr. Wood as a pathologist. It happens rather frequently.

MR. CUNNINGHAM: It must be rather unusual. It isn't anybody's fault, but the fact is that these specialists are set apart by an economic circumstance.

DR. WOOD: Say you have a little

tumor. A surgeon is going to remove it, and he's going to tell you, "Well, now I have to send that to Dr. Wood and get his opinion, not only as to the diagnosis, but for his opinion as to what the future holds for you."

MR. CUNNINGHAM: Yes.

DR. WOOD: "Dr. Wood will be sending you a consultant's bill." That's the way my clients work, and there is never any question at all, and the people know what it is. Otherwise it just appears on the hospital statement as a lab charge, or something like that.

DR. LITTAUER: I assume that your hospital is a member hospital of your local Blue Cross organization and Blue Cross provides that a certain amount of routine laboratory work will be furnished the patient. Does the patient consider that he's getting a consultation? Does the Blue Cross organization consider that as consultation?

DR. WOOD: He doesn't for my work, because I do just pure tissue pathology.

DR. LITTAUER: Well, I'm talking about the pathologist who is also director of laboratories, which is the usual thing, and certainly his work in clinical pathology, for the most part, is not that of a consultant.

DR. WOOD: Probably a good part of his clinical pathological work would be in the rôle of a consultant.

MR. HAYT: Well, I think that the problem really narrows itself down to one thing, and that is of an economic nature: How can we give security to the specialist? I think that every hospital administrator is willing to concede that not only should the specialist have security, but I am quite sure that the administrator would like to see similar security for every member of the medical staff, including himself.

DR. CHAMBERLAIN: Yes.

MR. HAYT: Now, Dr. Chamberlain, will you tell us how you think that economic security could be achieved not only for the specialist, but for the other members of the staff, including the administrator himself?

DR. CHAMBERLAIN: Well, Mr. Hayt, I have no idea how to give security to the administrator himself. He has one very valuable asset, and that is that he has contact, a very personal and very fine contact, with the board of trustees, and I have always felt that the hospital administrator had the best chance of anybody to impress himself upon the trustees as a valuable member of the organization, and that he got security in that direction.

DR. LITTAUER: I think Mr. Cunningham could say something here about the high turnover among hospital administrators!

DR. CHAMBERLAIN: With regard to the other members of the staff, of course they have security in proportion to their ability, because as they build a practice, they build a clientele for themselves. They are establishing themselves with relationship to the community, so that they are known and their services are sought for.

MR. CUNNINGHAM: Also, with relationship to one another.

DR. CHAMBERLAIN: Exactly.

MR. CUNNINGHAM: I'd like to make a point in that connection. To the extent that the physician's security derives from his association with other physicians, it is based on his competence, of course. It also derives from the association together of physicians in the hospital staff.

DR. CHAMBERLAIN: That's right.

MR. CUNNINGHAM: To which there is a corporate contribution.

DR. CHAMBERLAIN: That's absolutely right.

MR. CUNNINGHAM: Which ultimately should find expression economically, in some way. It is one of those intangibles that would be difficult to evaluate, but probably should have some evaluation.

DR. CHAMBERLAIN: You mean that every member of the staff ought to contribute to the hospital in some financial way on account of receiving patients as a result of this association?

MR. CUNNINGHAM: Every member of the staff does, in one way or other, doesn't he? I mean —

DR. CHAMBERLAIN: Well, he hospitalizes patients.

MR. CUNNINGHAM: That's right. It is an association that is characterized by mutuality. Now, I am getting back to a question I asked a lot earlier: What is a proper evaluation of the contribution that this organization factor of the hospital contributes to these specialty practices? That certainly is a point that belongs in this discussion, I think. Isn't that right?

DR. CHAMBERLAIN: Yes.

MR. CUNNINGHAM: How can you evaluate it?

DR. CHAMBERLAIN: I evaluate it this way: It enables the hospital to get a more successful type, a more competent type, a more experienced type of specialist than the hospital could get if it didn't have something besides the drudgery to offer, and I believe that it should be used that way. What I really want, as I said a while ago, is for the best radiology to be practiced in hospitals, and I tell the young men I teach, "You are not a real success unless you arrange to work in a hospital, because in an office practice certain very important opportunities for service are denied to you, and the most interesting cases are denied to you."

MR. CUNNINGHAM: You are talking about success. You want your young men to be successful, and you want them to be successful in a hospital practice because they can do more good there. Possibly they could make more money in an office practice. What do you mean by success?

DR. CHAMBERLAIN: I have my own definitions of that. At one time, in 1920, I was in a private practice, I had my own office in an office building, and I was making more money than I have made at any time since. I left that and went to Stanford medical school to be the head of the department of radiology there, because I saw an opportunity for what I call success, developing myself as a teacher, as a research worker, and as a practitioner in the most important cases that a radiologist gets a chance to work on. I have never regretted it, but I did learn some rather interesting lessons there.

When I first took this appointment, my predecessor had left radiology and gone into internal medicine because he didn't like the trends in hospital radiology. He said to me, "Don't you know that it is wrong for you to accept a salary and let them collect your fees?"

I didn't see anything wrong with that until in 1928, after I had been there eight years, the superintendent of the hospital came to me and said, "Look here, we have been making $30,000 a year profit from the x-ray department, and I have been able on the strength of that profit to prove to the board of trustees that we ought to build a private pavilion. We would have 277 private beds under those circumstances. Today we only have seventy-seven private beds, and if we could do as well as we have done on seventy-seven private beds, think how much better we can do with 277 private beds!

"Now in budgeting for the additional expenses that will go with the operation of the x-ray department on

(*Continued on Page* 114.)

THEIR OWN CLINIC

solves the doctors' "housing problem"

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THE Danville Polyclinic, Danville, Ill., was developed by three local physicians, Henry F. Hooker, a surgeon, Jean W. Moore, medicine and surgery, and Henry P. Lattuada, obstetrics and gynecology. When Dr. Moore and Dr. Lattuada returned from military service they found, like many other physicians, that there was an acute shortage of office space. The idea of purchasing a building and remodeling according to their needs started them on the way to developing a group practice arrangement that included other physicians plus a laboratory, x-ray department and pharmacy.

A two-story brick building with a full basement located in the downtown section was available, and this was purchased by the three physicians in the early part of 1946. A parking lot adjacent to the building was also obtained. Plans for remodeling were drawn up by E. M. Blackman and G. M. Strader, local architects.

A corporation was formed to own and manage the building. It was felt that this would be more practical than requiring each physician who joined the group to purchase his proportionate share in the building. The financing is therefore carried largely by the original partners until such time as the others feel they are able to assume a greater share. The group or partnership rents the space it uses from the corporation. In time, all the physicians in the group could own equal shares in the corporation, but it is not necessary that they do so.

The original plans, as shown, provide space for eight physicians, including radiologists, whose department is in the basement. Further remodeling of the remainder of the space will provide quarters for three more physicians. The reception room will also be enlarged to double the size shown in the floor plans.

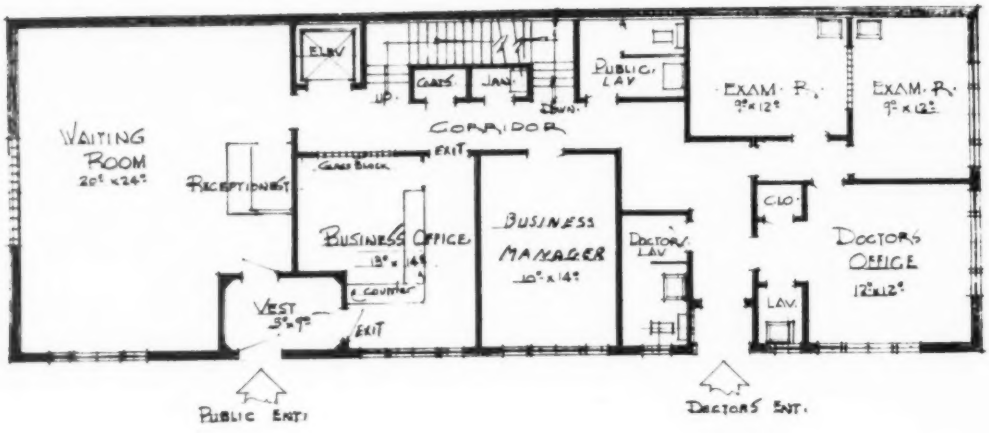
By September 1947 the physical plant, as shown, was ready for operation. The eight physicians included the three original partners plus specialists in eye, ear, nose and throat, internal medicine, orthopedic surgery, radiologist and a general practitioner. The internist, orthopedic surgeon, and radiologist were young physicians just released from military services The group arrangement offered these young physicians space to practice without a large investment on their part and the opportunity to start practicing with physicians well established in the community.

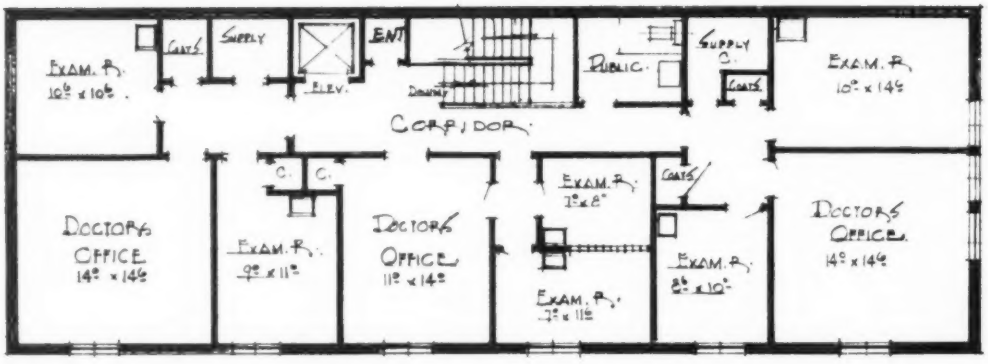
The x-ray department and laboratory are located in the basement. One technician is in charge of the laboratory, and two technicians work in the x-ray department. However, the three technicians are trained in both laboratory and x-ray technics so that they can work in either department if necessary.

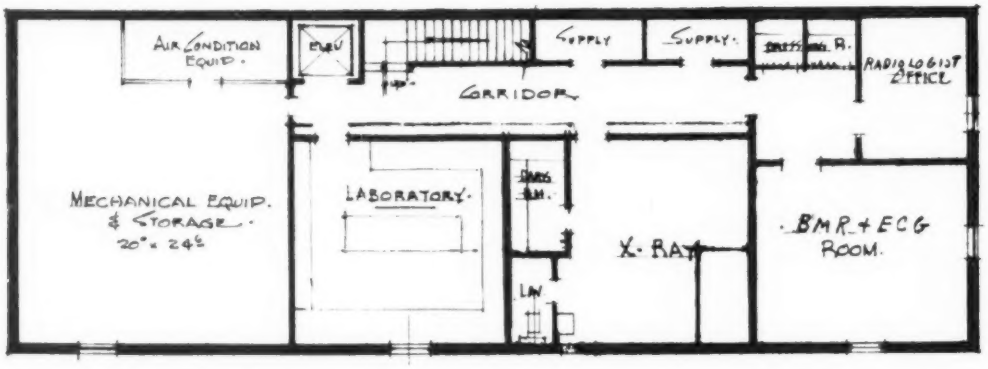
The new plans will put the orthopedic surgeon's office in the basement also. This will make it easier for his patients to be referred to x-ray for examination. An x-ray therapy unit may also be installed in the basement, and the remainder of the space will be used for a record room. With an automatic elevator, plus the stairs, there is no problem in having the various departments and offices on three levels. Patients who find climbing stairs difficult or impossible are moved via elevator and wheel chair if necessary.

A prescription pharmacy is located on the first floor. It has its own street entrance but can be entered directly from the clinic also. The pharmacy

DANVILLE POLYCLINIC
DANVILLE ILL.







TOP: Plan of the first floor showing the layout of the business offices, reception and waiting room and pharmacy. The pharmacy has an entrance from the street as well as one from the clinic. CENTER (second floor): Each physician has an office and two examining rooms. BOTTOM: The laboratory and x-ray department are housed in the basement and the new plans will put the orthopedic surgeon's office in the basement also.

Left: First floor looking toward the reception room. Right: Receptionist.

is operated by a local pharmacist. Like the physicians, he leases his space from the corporation.

As indicated in the floor plans, each physician has an office and two examining rooms. The interior of the clinic, including the physicians' offices, is finished with walnut paneling and doors, with the walls painted a light green. The building is air conditioned. All furnishings and equipment are new. The floors are covered with composition tile that is easy to clean and polish.

Each physician has his own nurse who makes his appointments and assists him in the office. Patients are seen by appointment, except emergency cases, from 1 p.m. to 6 p.m. except Saturday afternoon and Sunday. The clinic is open one night, Monday, from 7 until 9. The x-ray department and laboratory are, of course, open all day, and the nurses also see patients for routine injections or dressings in the morning. Appointments for x-ray and laboratory examinations are made by the physician or his nurse directly with those departments. Advance scheduling is made for the morning hours primarily in order that these departments will be free to handle patients sent directly from the physician's office in the afternoon.

As shown in the floor plans, the main entrance to the clinic brings the patients to the reception desk. Two receptionists are employed, and they also operate the switchboard. On the patient's first visit to the clinic, routine information, such as name, address and the person responsible for payment, is obtained by the receptionist. This information is placed on a permanent record card and filed at the receptionist's desk. For future visits the patient is not required to give this information.

On the first visit the receptionist also heads up a case history form for the patient. Each nurse handles the case history forms, as well as laboratory and x-ray reports for the physician. All medical records are filed in the record room; there is one folder for each patient. One girl is in charge of the record room, although the nurses are responsible for having the records on hand for each physician according to the schedule of appointments for that particular day.

A list of appointments for each physician or department is turned over to the receptionist each morning. From her permanent records she makes up individual appointment slips for each patient. The patient keeps this appointment slip with him, and each physician or department records briefly the service rendered and the charge. The slip is then turned in to the cashier as the patient is leaving. Payment may be made at that time or, if it is a charge account, a statement is sent at the end of the month.

These appointment slips are numbered and accounted for each day. From these slips the business office makes the patients' ledger accounts. An individual ledger account in the form of a card is maintained for each patient. These are filed alphabetically in the business office, and the charges and payments are posted daily. A standard electric posting machine is used. The daily charges and payments are posted in duplicate. The statement fits over the ledger card so at the end of the month the statement can be sent out and a new statement can be placed on the ledger card for future posting. The type of service and the physician's initials are shown so that patients receive an itemized statement of dates, type of service, charges, payments and balance due. The ledger card provides a permanent record for the business office on each patient.

The business office also handles all reports required for payment, such as compensation cases, old age assistance, and direct relief cases. Information on diagnosis and treatment is obtained from the case history and the physicians. Notations are made on the patient's appointment slip so that the necessary paper work involved in these cases is started immediately. Such cases frequently require considerable reporting but must be done in a general practice clinic that serves an immediate surrounding community.

New patients who do not request a particular physician are referred to one of the general practitioners unless they provide sufficient information to indicate that they need the attention of the specialists. The receptionists refer any case they feel is not routine to the business manager's office. The secretary, as well as the business manager, is qualified to handle problems regarding the routing of patients, charges, insurance and methods of postpayment arrangement.

The physicians make their own charges in each case. The county medical society fee schedule is followed. The minimum fee for an office visit is

Left: Cashier and bookkeeping office. Right: Section of the pharmacy.

$3. Laboratory and x-ray fees are similar to those charged in hospital laboratory and x-ray departments in that area. Because the group is still small, consultation is carried on informally; one physician calls in others in the group as the need arises. If a physician in charge of a case feels it is necessary, he may arrange for a patient to be examined by two or three of the specialists.

Inasmuch as the physicians also work together in the hospitals, a schedule of operations is maintained at the clinic as far in advance as possible, usually three weeks. The surgeons then work out their teams ahead of time according to the type of cases. A local general practitioner, who has had special training in anesthesia but is not in the group, also works with the group in the hospitals.

All charges for services rendered in the hospital are made through the clinic office. In most cases the anesthetist's fee is also charged and collected through the clinic office. This fee—when collected—is turned over to the anesthetist and is handled in this manner as a matter of convenience. The person responsible for payment is advised, in advance if possible, of the amount of the fee for the surgical procedure and for the anesthesia. No difficulty arises when this person receives a statement if he understands the reasons for the separate fees.

As stated, the physicians are organized as a partnership, with all charges handled through a central office. All operating expenses for the clinic are paid from gross collections, and the remainder, the net income, is divided among the partners on an agreed upon percentage basis. Each physician has a monthly drawing account, and the final division is made annually after the financial books are closed for the year and audited.

Records are kept to show the charges and collections by physicians and departments in order to provide additional information and data for revising the percentage distribution of the net income. Factual data of this nature, plus informal discussions, enable the physicians to work out a satisfactory fiscal arrangement. Regular staff meetings are held to discuss specific problems at least once a month. Financial reports and reports on personnel, equipment and procedures are considered at that time.

A business manager is employed to handle the nonmedical functions of the organization. Good accounting procedures are essential to maintain accurate and up-to-date figures on all phases of the organization. Statements are sent out regularly and on time. If payment is not received after three statements a follow-up letter is sent to find the reasons, and some plan of payment is worked out. If no response is received, the accounts are turned over to a local credit and collection bureau. Insurance cases, old age assistance, and direct relief cases all require special billing, and payment will not be received unless the particular procedure is carried out correctly and on time.

Monthly financial reports for the partnership contain information on collections, charges outstanding, and expenses, with proper consideration being given to anticipated depreciation charges on equipment, taxes and other governmental reports that are required of organizations but do not arise in individual practice.

The employment and allocation of nonmedical personnel cause some difficulty because the activity at the clinic varies throughout the day, and the working day is not over until all the patients have left.

The clerical personnel must be capable of filling more than one position and the hours of work are staggered in order to provide sufficient help when and where it is needed. It is not easy to find the right balance in the number of clerical personnel that will give every phase of the business side proper attention and still keep operating expenses at a minimum. It is important that the receptionists and the cashiers be able to give each person prompt attention and to spend sufficient time in each case to handle it properly.

Good medical care is the prime objective of the organization, but the patient's evaluation of the service he receives also includes the manner in which the nonmedical personnel treats him. The ratio of other personnel, including nurses and technicians, to physicians will run between two and three in a group arrangement.

The physician's chief benefits in a group arrangement are not financial, since operating expenses are usually greater than in individual practice. He will, however, be able to devote more time to medicine and will have the advantage of close consultation and laboratory and x-ray services immediately at hand. The patients benefit from these same things.

On the human side of the hospital

ROBERT WOOD JOHNSON
Author of "Or Forfeit Freedom"

THE hospital, like many other institutions, faces a maze of problems. On the material side it deals with money, buildings, equipment, upkeep and repairs. On the human side, difficulties arise from the relationships between executives, medical and nursing staffs, as well as between all professional groups and the lay employes. The last, especially, pose problems of their own, which range from indifference and sullen resentment to trouble-making and open rebellion. At best, they reduce efficiency; at their worst, they threaten the reputation and usefulness of the institution.

UNIQUE IN ONE RESPECT

Trustees and administrators often feel that these problems are unique, and in one respect they are. Unlike stores, hotels or railroads, hospitals do not deal with normally healthy people. By their very nature, they serve persons who are ill, injured, alarmed, discouraged, and who often are very poor. Moreover, the advances of medical science place a premium on skill, intelligence and teamwork, throwing every failure into sharp relief.

These facts increase the strains and tensions of hospital administration, but do not make them unique. The hospital is a human organization; its work, like the work of any other establishment, must be done by men and women. Its problems therefore are only special aspects of problems that face the business world, and it is reasonable to think they can be solved by methods which business has found useful.

Human problems that now plague the business world arose at a time when men were supposed to work only for money, and profit was the only goal of commercial enterprise. Those of hospitals come down from the day when institutions cared only for the indigent ill. Some drew their lay and nursing staffs from religious orders; others relied on the chronically unwell, the partly disabled, or on the unskilled and maladjusted who could find no place in industry. Against this background arose a system of discipline in which everyone obeyed orders. With discipline went a rigid caste system in which administrators, doctors, and nurses occupied the three uppermost strata. Below these came a series of levels for technicians, orderlies, and so on, descending to a basal stratum of "untouchables" who washed dishes and scrubbed floors. Each level said *yes* to all levels above it, and looked down upon all levels below.

This system worked surprisingly well for several decades. Looking back, we realize that they were decades during which medical and surgical care was relatively simple, requiring little skill on the part of nonprofessional workers. The period also was one of a large labor supply, when workers outnumbered jobs and people were glad to find employment regardless of its conditions. Finally, the time was one during which labor was unassertive; when it was unaware of its rights and dignity as human beings and did not demand humane treatment by employers.

These conditions kept the system going while they lasted, but they no longer exist. The staff of a modern hospital must possess expert knowledge and ability, while docility and competition for employment have vanished. Nurses now speak sharply to supervisors; orderlies talk back to nurses; cleaning women show resentment by slighting their work or walking out when they are reprimanded. When these workers quit, the hospital administrator is hard put to replace them. In doing so, he must compete with business—and business, which earns profits, is able to outbid him. Too often, it leaves only workers who are discouraged, maladjusted or even subnormal. From these the hospital administrator must fill vacancies in his lay, or nonprofessional, staff.

The danger of such conditions is clear. What can we do to improve them?

Improvement must begin, I believe, with reorientation of thinking on executive and professional levels. It is not enough to say that hospitals face problems of efficiency, problems of discipline, or the problem of getting enough money to hire competent employes. Hospitals, like business houses, find themselves in a new era in which employes refuse to be treated as menials or as spiritless automatons. Instead, they assert themselves as human beings, with the rights and requirements inherent in men and women. Since this era is here, and here to stay, hospitals must accept it, adapt themselves to it, and utilize its opportunities.

CHALLENGE HAS BEEN MET

The means of doing so have already been explored by commerce and industry. As we have said, every business house faces difficulties comparable to those encountered by hospitals. Progressive businesses have met the challenge by establishing professional personnel departments. These, in turn, have developed new procedures of hiring, training, dealing with grievances, and elevating morale. All are planned to make the most of the human resources on which every enterprise depends.

Let us now suppose that a hospital has determined to apply a similar solution to its personnel problems. That decision must be made by the trustees after consultation with administrative and medical staffs, all of whom must be

ready to stand behind it. The next step is to engage a personnel director or—if the hospital is too small to hire one—to borrow the services of an expert from local business. The record shows that business generally is both able and willing to lend executives for part-time work in any hospital that needs them.

The administrator faced by over-all problems must be prepared to see his personnel director start with seemingly trivial things. Were I such a man, I probably should begin by fitting out an attractive office in which applicants for jobs could be received and carefully interviewed. While waiting for this office to be built or decorated, I certainly should get a competent stylist to redesign the uniforms of lay employes. Almost without exception, those uniforms are now unattractive and ill-fitting. Worn without ironing, as they sometimes are, they make the wearer look—and probably feel—like a walking "rough-dry" laundry bundle. It is hard to believe that any person so attired can feel pride in himself and his work or can believe that the institution values and respects his services. Yet no worker who lacks pride and assurance of respect is likely to do a presentable job.

CAREFUL TESTS NECESSARY

The next task of the personnel director is to improve hiring practices. These now range from half-hearted attempts at thoroughness to uncritical acceptance of almost anyone who comes to ask for a job. As a result, many hospitals actually find themselves with lay staffs that include criminals, mental and moral misfits, and people who lack ability to follow directions for performing even the simplest jobs. This can be prevented only by careful interviews and checkups, followed by tests to determine interests and aptitudes. These tests should enable the personnel director to hire the best applicants available and to place them where they can give the most satisfactory service to the institution.

It is not enough, however, to hire good people; the hospital must also turn them into good and efficient workers. This can be done by training, though not the kind that allows a new employe to watch an old one for a day and then tells him to go do as well. Modern training begins with orientation, which gives the employe an understanding of his place in the hospital, shows him the purpose and value of his work, and explains rules and policies by which he will be affected. This must be followed by specialized job training, which is just as necessary for cleaning women as it is for orderlies and cooks.

These are not small tasks, yet modern training goes farther. It shows the employe how to work effectively, so that he wastes a minimum of effort and obtains best possible results. At the same time, training proves to him that he is respected and appreciated and convinces him that his services are valued by the hospital. Later, as the employe proves himself and acquires experience, he may be given still more training designed to improve old skills, develop new ones, and enable him to take a more responsible place in the hospital staff.

The final task for the personnel director is to develop a new feeling of partnership throughout the lay and professional staffs. Interviews show that dissatisfaction and resentment now are widespread, especially among lay workers who resent the superior attitudes of doctors, nurses, laboratory technicians, and other professionals. To a lesser but still serious extent, nurses feel resentment toward doctors, regarding many of them as autocrats who give the nurse little credit for knowledge, skill or judgment in dealing with patients. Physicians and surgeons, in turn, resent what to them is the surly attitude of some nurses, and are forthright in their condemnation of inefficient and indifferent lay employes. Aware of these seething currents of ill will, the administrator too often falls back upon iron discipline in an effort to keep things under control.

Discipline prevents explosion; it remedies no evils and frequently aggravates them. To achieve a remedy, those who manage our hospitals must scrap the outworn caste system and deal with all staff members as self-respecting men and women. This relationship often exists between doctors and administrators; it should be extended without delay to nurses and technicians. The day has passed when the nurse was merely a handmaiden; when the technician merely went through motions prescribed in a manual. The modern nurse, the product of years of training, is a skilled and responsible person who is ready, and who should be allowed, to act as the doctor's junior partner. The same is true of the technician, whose tests and reports form the basis of much surgical and medical work.

A greater gap exists between the professional and lay personnel. With few exceptions, today's lay employes are not exceptionally able people, nor do they possess technical skills developed by years of education. Still, they are people; they do have abilities, and those abilities can be improved by opportunity and training. Surveys indicate, moreover, that more and more of the hospital's technical work can and probably must be turned over to competent lay personnel, just as much work once done by student nurses is now handled by orderlies and maids. The surest way to achieve this result is to raise the status of lay employes, at the same time hiring workers who can meet increased responsibilities.

The objection is sure to be made that all this will cost money—more money than hospitals can afford. The hospital, it will be pointed out, is not a business institution; it cannot spend in hope of increasing its income, nor can it freely raise prices to offset increased costs. It has to live within its income, and it must give essential service for the fewest possible dollars and cents. It therefore is forced to economize, even at the cost of inefficient and indifferent or resentful workers.

HOSPITAL IS A BUSINESS

This objection seems to be well taken until we analyze its background. Then we find that the hospital actually is a business in the sense that it buys materials, employs workers, and sells service. Like any other business, it is compelled to improve its service in order to keep pace with advancing knowledge and technical progress. It also must reduce its costs, in order not to price itself completely out of the market. In other words, it must hold down costs per patient day to figures that can be met by payments from the patients and by other income.

Let us first consider the problem of service, which worries many administrators and many a medical staff. Business faces this problem every day; on the material side, its solution is to devise new products and processes and install new machines, much as the hospital keeps up with the times in methods and equipment. On the human side, business meets the challenge of service by raising wages to levels that attract good workers, by developing their capacities through training, and by raising their morale. All these cost money, but all produce satisfactory results.

We next consider the question of costs. Although there still are a few skeptics, the record proves that modern personnel methods, including careful selection of employes and thorough training, reduce costs per unit of product, which is the business equivalent of the hospital's patient day. There is no reason to believe that these same methods, supported by labor-saving equipment, will be less successful in hospitals. Initial costs will be higher, of course, but greater results will soon turn them into savings instead of increased expense.

Let me repeat, however, that no sound personnel program can exist without the support of trustees, administrators and influential doctors. During recent years I have seen a few hospitals and many business houses install personnel departments much as one might adopt a temporary fad in dressing. The change is conspicuous but not deeply rooted, and it does not last. The personnel director soon finds his work canceled by opposition from people who consider him an intruder. Since he can neither persuade nor control them, he therefore goes elsewhere, and conditions return to the status quo from which he had hoped to raise them. It is better to make no effort at all than to embark on one thus foredoomed to futility.

In the long run, of course, we cannot afford either to fail or to do nothing. We must have hospitals, and hospitals must have staffs that will give adequate service. The only way to get them is to scrap our outmoded caste system and all that goes with it. To do this, we must first raise the status of lay attendants to that of lay technicians.

At the same time, we must develop a feeling of partnership, a sense of teamwork, throughout the entire organization. Indeed, we must go much farther and, in the words of Dr. Malcolm T. MacEachern: "Inculcate a spirit of devotion, of self-sacrifice, of unflagging zeal, in the interest of the patient. This can never be accomplished if the employe is not treated with exceptional consideration. A partner attitude toward personnel will be reflected in their acting as partners with management in giving the patient superior service."

That, of course, is the only kind of service hospitals can be content to provide.

Why the Campaign Was Oversubscribed

JAMES E. WERLE
Superintendent
Meadville City Hospital
Meadville, Pa.

THE effectiveness of hospitals in small industrial cities in submerging their separate interests to common benefits was pointed up in Meadville, Pa., last spring when a United Hospital Fund campaign for $950,000 in that city of 27,000 population mounted to $1,101,162.89.

When the city's two hospitals, Spencer Hospital, and Meadville City Hospital, both found themselves confronted with large scale replacement and expansion programs, the boards were quick to perceive the folly of undertaking individual campaigns, one after the other.

Months of intensive study and planning to coordinate improvement programs, to eliminate unnecessary duplication of specialized facilities, and to prepare arrangements for a joint campaign followed. A policy committee with representatives from the two hospitals was established to develop campaign details.

The immediate objective called for eighty additional beds and extensive improvements to the emergency, specialized and service departments by construction of new wings at both hospitals. An addition to the nurses' home at Meadville City Hospital was also included among expansion plans. The over-subscription that resulted will assure this construction and will permit even more extensive enlargement and modernization of facilities in both institutions.

Early in the planning, the services of a professional fund-raising organization were engaged, and the entire campaign was under the direction of this firm. A four-man staff was on the job for about three months during the intensive phase. Actual solicitation, including advanced gifts, covered a period of only thirty-two days.

During the preliminary period the local newspapers cooperated fully in presentation of publicity and in endorsement of the united appeal by the two hospitals. Meadville industrial management, long harassed by successive and often duplicating campaigns, greeted announcement of the cooperative effort with an enthusiasm that resulted in valuable support.

Much time and effort also were used in bringing labor and management together, making it possible to solicit working people at their places of employment, and to obtain approval for the pay roll deduction plan.

Because of the united appeal, special emphasis was placed on creating a wide base of giving with results that were stimulating to the entire campaign organization. The general acceptance of the campaign was reflected in the 11,055 individual subscriptions which were registered.

Employes compiled a high standard of giving with 2401 Talon, Inc. workers subscribing $100,000 for an average of $45.78. McCroskey Tool Company employes, numbering 159, subscribed $7432.50 for an average of $46.94.

Largest industrial gift of the campaign was $160,000 from the Talon, Inc. This subscription was made as a result of a contingent arrangement whereby the corporation agreed to add 20 per cent to every dollar obtained from other sources. Executives of Talon, Inc. also subscribed an additional $48,000.

More than 450 volunteer workers participated in the campaign conducted throughout Meadville and fifteen other smaller communities served by the two hospitals.

At conclusion of the joint fund-raising effort, local newspapers praised the boards of the two hospitals for their vision in sponsoring the campaign together. The editor asserted that the hospital campaign, resulting from a study of the total community needs, served as a splendid example of putting the community's welfare above any self-interest on the part of the institutions or individuals.

Left: Makeup practice teaches students the fine points of application of cosmetics with due regard to color type and facial contours. Opposite Page: "Keep your stomach in, Sister." Good posture is important to good looks and health.

There's nothing frivolous about this CHARM COURSE for NURSES

EDWARD E. JAMES
Public Relations Director, Bradford Hospital, Bradford, Pa.

LAST summer Bradford Hospital, Bradford, Pa., brushed away some of the cobwebs on the nursing curriculum by announcing a "charm course" to be given in conjunction with its school of nursing. Publicity-wise, and as a morale booster for students, it was an instant success; but it became increasingly evident that the problems of conducting the course might offset or even outweigh the anticipated advantages. During the past several months, the problems inherent in a project of this nature have been experienced and, we hope, satisfactorily solved.

The hospital was fortunate in having the professional advice and collaboration of the person with whom the project had been discussed originally and who agreed to take the course over. Miriam Kreinson, director of the Miriam Sage Kreinson Studio, a local woman with boundless enthusiasm and a long teaching experience, had organized and coached almost every sort of performing group and conducted classes in carriage and posture correction; yet she was without direct experience in running the sort of course we had discussed.

It was obvious once the curriculum was established that experienced, interested teachers had to be found, for the hospital did not wish to expose its students to dispirited, cut and dried instruction. Bradford is a small city — population 20,000 — and is peculiarly isolated despite its northwestern Pennsylvania location, and it seemed unlikely that the kind of instructors desired could be located in or near it. It was felt that upon this point the entire success or failure of the course rested.

The teaching problem was solved when Miss Kreinson realized that competent teachers were to be found among other friends of the hospital. And—all the more remarkable—all were local people, not transients. Makeup and hair styling were taught by a former instructor in a Fifth Avenue "success school," an attractive young woman now a professional photographers' model; instruction in clothes selection and economies was given by a professional man's wife, formerly a ladies' wear buyer; voice, speech and "presence" were taught by a woman who before becoming a mother had taught speech and voice for the stage and acting technics for four years in Eastern women's colleges, and had eight years of acting experience; and carriage and corrective exercises, by Miss Kreinson and her assistants. All agreed that the level of instruction was remarkably high, with each instructor well qualified in her field.

Once the teaching organization was complete, the problem was redefinition of the purpose of the course. The school of nursing certainly did not want to turn out overdone, superficial, self-centered nurses who would be more interested in

manicures than mankind. It was recognized, however, that nurses could perform their nursing duties more thoughtfully and effectively if they were free of anxieties about their personal appearance and acceptability. The real purpose of the course, therefore, was to build up the students' personal assurance, which in turn would make them better nurses, and it was to this end that the classes were planned.

The subject matter of the courses was for the most part elementary. The classes were intended to emphasize basic principles only, and to give students pointers which they could employ in everyday living; the hospital was not running a training school for professional models. Much of the information could have been gleaned by the students from various sources, such as womens' magazines, but was of the sort that when presented in an organized manner had a much greater impact. Then, too, the semi-laboratory aspects of the personalized instruction were important.

Susie, whose mother had always said Susie should never wear her hair any way but long, freed of her mother's influence could at last see that a different hair styling made her appear more attractive and less like a little girl—a real contribution to her self-assurance when dealing with patients. Well meant but critical comments which ordinarily might have been unacceptable were passed back and forth in classes and accepted by all in the spirit in which they were intended, another advantage of group participation.

Classes were held during regular class hours, usually at the convenience of the outside instructors. Ready access from the classrooms to the nurses' residence made instruction in makeup and similar subjects easy, for students were able to reach their rooms without being seen by the public.

The number of hours devoted to each subject was held to the minimum required to present basic principles, and students were encouraged to practice on their own time. Usually the "practice" consisted merely of approaching with a new insight something that had been done without thought for years. For example, one student remarked that even though she had frequently heard playbacks of her recorded voice on a machine her family owned, she had not realized how atonal her voice was until after a voice and speech class. In this as in other cases the student was easily able to practice what she had learned without stealing time either from her nursing studies or from the period ordinarily given to recreation.

The class schedule follows:

Makeup and Hairdo: Analysis of best features, tricks in minimizing structural defects; proper application of foundation; blending of cosmetics for color type; placement of rouge; shaping of eyebrows; use of shadow and mascara; relation of natural makeup to fashionable trends. Two hours.

Hair Styling: Analysis of individual hair style needs in line, proportion, length; care of the hair; practical and "glamorous" hair styles. Two hours.

Carriage, Standing and Sitting: Analysis of figure faults and specific remedies (exercises, games); poise in movement; detection and relaxation of tensions in movement. Two hours.

Wardrobe Planning: Selection of clothes with consideration of figure faults (heightening the short figure, softening the angular figure); the minimum or basic wardrobe and its selection; tricks in varying the basic costume (use of jewelry, accessories and other accents); tips on good buying, including durability of fabrics, recognition of good tailoring; care of the wardrobe. Two hours.

Voice and Speech: Development of a pleasant speaking voice, including

DIRECTOR OF NURSES SAYS:

WE THINK the "charm school" recently given here was successful. A number of desirable ends were accomplished, many of which could have been realized in no other way as easily.

This does not mean that there was no criticism, however. Charges that nursing time was being given for unessential purposes were easily met, for the preclinical students would not have been responsible for nursing service anyway. Criticisms that some students needed other work "more" were quite accurate, but in terms of the long-term advantages of the courses compared with immediate results of increased technical knowledge, we felt our timing of the charm series to be the best possible for all concerned. Some other objections to the classes were, of course, rooted in sheer inertia or resistance to anything new and progressive.

What has been accomplished? Primarily, each student has been made to realize that she must "sell" herself before she can sell her services, a point often overlooked in patient-nurse relationships. The student has, furthermore, been acquainted with the technics she can employ to bolster her self-assurance. Third, and perhaps most important, students' mental hygiene has been noticeably improved (a logical consequence of the other two accomplishments).

In addition, many outsiders have been caused to realize that nurses and other hospital personnel are human beings with desires and objectives—and weaknesses—much like their own. Maybe we are imagining it, but it seems that the public has been a little more reasonable and appreciative lately. Then, again, although it is too soon to say definitely, that attitude could be an effect of the course, a result of what we had hoped to accomplish when we started it.—FLORENCE SIEWERS, R.N., *director of nurses, Bradford Hospital.*

breath control, pitch, resonance and volume; analysis and correction of common faults in diction (enunciation, phrasing, intonation). Two hours.

Presence: Tact in taking typical situations in hand as a nurse. One hour.

Expenses were held to a minimum, with the only unusual additional expense coming through the purchase of a few dollars' worth of cosmetics which students used for experimentation. Even this might have been avoided if students had been required to purchase their own makeup kits (available for $2 apiece) at local drugstores.

A continuation of the course or, more properly, an extension into a somewhat different field is being considered. To date the approach has been based on building up the nurses' assurance. This in turn depends upon the awareness of students of other peoples' ideas about them. By making them become more aware of patient reaction, students are already learning to observe more closely the emotional response of patients to all nursing acts, an ability otherwise coming largely only with age and experience in nursing. However, if students can be taught earlier to view their service through the eyes of the patient, as well as from a strictly therapeutic standpoint, a great contribution to effective bedside (or administrative) nursing will have been made. The patient then will be treated as a whole being, not merely as a "case."

To achieve this end—and there have already been many approaches to it, none of which would appear to have been wholly successful, to judge by present-day attitudes—a series of discussion classes using popular books on personality development is contemplated. Recognition and appreciation of the patient would be the primary consideration, with character building or defect correction not treated as such. However, if students could be made aware of the contributions to social popularity of such basic attributes as consideration and reasonableness, some character reeducation resulting in treatment of patients as nurses themselves would like to be treated could be accomplished.

The literature being considered, based wholly on the marketability of "personality," has been used for years in industry to accomplish superficially similar ends in foreman-worker relationships. In their basic assumptions these texts are cynical, but it will be stressed that long-term effectiveness of the technics depends upon the interest behind their employment; patients cannot be deceived for long if real interest is lacking. Unfortunately, there are few books (or other shortcuts) which help nurses achieve personal maturity, to which a course of this nature will ultimately contribute.

The success of a program of the sort being given at Bradford Hospital is not easily measurable. We (who admittedly are prejudiced) think the courses are worth while, for they have raised student morale, stimulated interest in our school of nursing, quickened awareness of patient reactions, and even pointed toward new teaching technics to rekindle the spirit of charity in nursing. The ultimate test will, of course, come when patients express their opinions of the care they receive.

The Things Insurance Doesn't Cover

LEWIS H. ROEMISCH
Assistant Administrator and Comptroller
W. A. Foote Memorial Hospital
Jackson, Mich.

IF JIM JACKSON bought his fire insurance on the same basis as he buys his hospital insurance, he would be adequately recompensed for a fire loss which occurred in his kitchen, even, perhaps his living room; but if his whole house burned down, he would receive from his insurer only the value of his kitchen or of his living room.

When automobile insurance companies handle collision coverage, it is invariably on the basis of coverage for large losses, with minor losses paid for by the insured. Witness the deductible clause of $25 or $50 in all automobile collision policies.

If we look over a typical hospitalization insurance plan as, for instance, our Michigan Hospital Service Blue Cross plan (and it is among the best), we find that it pays for full coverage, with certain exceptions, for thirty days, followed by 50 per cent payment for ninety days, and no payment at all beyond the 120 day period.

It pays, then, for the relatively minor case in full, but for the major case, the insurance covers only a proportion of the patient's loss.

Jim Jackson is an average man. He owns his home worth $7500; he has a car worth $1500, and he has, wonder of wonders, $1000 in the bank. He has a job paying $5000 per year, which looks not too big with Jimmy Jr., Mary and Mrs. Jackson to feed, clothe, educate and entertain.

Jim now decides to save a little money and clean his eaves troughs himself. These troughs have a way of being quite a distance from the ground. Jim, being more confident than agile, came down abruptly to the profit of only the orthopedist.

The hospital stay for Jim exceeded six months, and his hospital bill was $3000. His insurance paid $1000, and Jim had $2000 yet to pay. He also paid for special nurses during the first fifteen days, an additional $450, and his income had stopped for the total time of his hospitalization plus another 120 days at home before he could again go to work.

Jim is now literally "poor Jim." His cash savings are gone. His automobile is sold, and he has a $2000 mortgage on his home—and he was "covered" by hospital insurance.

What insurance would Jim like to have? What kind would really protect him against a major disaster?

Unfortunately, the answer is not Blue Cross. Nor is it any of the so-called "hospital insurance plans" of the commercial companies.

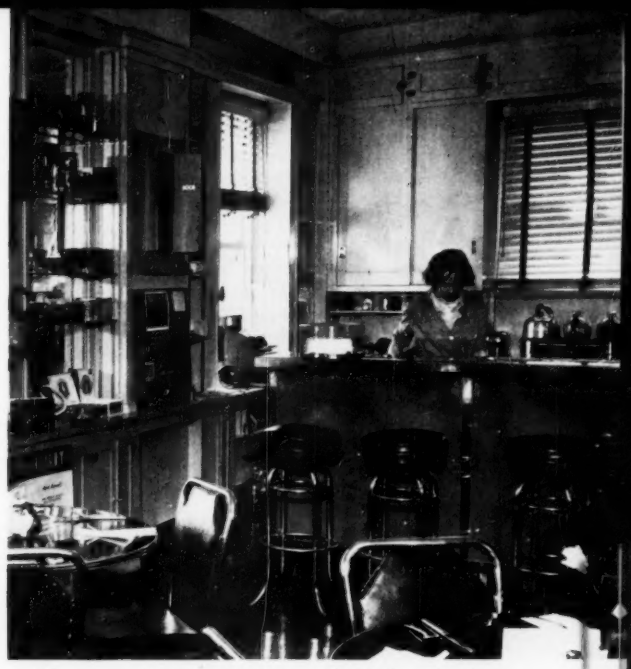
And while Jim's case is not the usual case, neither is it rare.

Jim is ready to welcome with open arms that insurance man who will offer to him complete protection.

Jim thinks that if he could buy a plan where he pays the first $100 and his insurance company pays all over that amount that not only should the premium be within his reach, but that he would be buying insurance to protect himself and his family from the major disaster. The first $100, feels Jim, is not hard to raise—the last thousands of dollars are, Jim thinks, almost impossible.

BEHIND THE SCENES IN A HOSPITAL SHOP

ELIZA H. WALMSLEY
Manager, Hospitality Shop
Mountainside Hospital, Montclair, N.J.



All is peaceful and serene (outwardly) before the doors open—but just wait until the customers start to pour in.

THERE is a part of every hospital shop that is intensely absorbing and vital. This is the part played by the paid worker.

But first, what constitutes a good paid worker in a hospital shop? She should be "all things to all people." She has much more than the average business woman's problems and personalities with which to deal. She must be liked and trusted by her committee. She must have the confidence and respect of her co-workers. She must have the ability to deal with the overworked and often temperamental doctor and hospital staff. And probably most important, she must possess warmth and kindly understanding for the many people who enter the shop, overburdened with fear for the loved ones in a critical condition "upstairs." And that is not all—she must possess business ability, physical endurance and a good working knowledge of food, gifts and the other "accessories" which contribute to a successful shop.

Few fully realize the pattern from which the average day of the average paid worker in an average hospital shop is cut. These shops open at various times, but even before that comes much preparation. Many a worker, as she enters the shop with a smile on her lips, offers up a little prayer that the smile may be maintained and that the day will not hold too many setbacks and upheavals.

Let us say it is Monday, and she arrives bright and early, rested and refreshed from a peaceful week end, with the firmly fixed idea that all is well with a very wonderful world and that absolutely NOTHING can go wrong.

So our heroine enters the shop with a satisfied smile and a song in her heart. But what is that puddle on the floor? And is there a slight odor of gas? Down she goes, literally on her middle, only to find a leak in the plumbing. A quick but comprehensive glance at the stove assures her that the pilot light is taking a vacation. Nothing really alarming and both can easily be remedied by a call to the maintenance department.

Next, the news company has seen fit to leave at least six large wired bundles of magazines. Why, oh why, must they send such quantities and why the *Police Gazette* for a little light reading in the sickroom? They will have to be called later and perhaps they may be amenable to reason and made to see the futility of so many graphic publications. In the meanwhile the magazines must be lugged off the counter stools, so that the early bird customers can reach their coffee. Here's hoping she does nothing to her sacro-iliac. The bundle was a bit heavy.

Food ordering comes next. She was going to have chickens, but somehow they have not materialized. Has she enough bacon? And whatever became of the eggs and celery she thought she had safely tucked away in the icebox. Ham is so expensive and bologna not too popular. The cream cheese won't be in until tomorrow and somehow the spiced ham was sliced too thick. Better chop it and make it into a spread. At long last she has what she thinks is a well balanced set of "specials," items that she hopes will prove both appetizing and interesting.

Now the cash for the register. Gracious! She has slipped in the puddle and dropped the money box. There go at least eight of her ten dollars in dimes and nickels all over the floor. Hurry now, it's almost time to open the shop and it won't take too long to get under the chairs and tables and do a fast retrieving job on the scattered cash. Fine, it's almost counted and in the register, but what is that hissing? Only the coffee popping over the coffee machine. It must be stirred. Did she have eight dollars in nickels all counted, or was it only five? She jumps behind the counter, gets the coffee straightened out and then back to the register. Soon the money is where it should be.

A long sigh—a quick appraising glance at the general appearance of the shop. It looks all right, except that several items in the cases need a bit of attention, having fallen on their faces. And the candy needs replenishing badly. Oh, well, it will do for now and she's almost ready to start serving. Doesn't that cream look

strange? A quick sniff confirms the fact that last night's thunderstorm or something else must have turned it. Down to the kitchen for another bottle. Then the doors can really be opened wide. She still has lots of pep.

Enter several people who have been waiting all night for a visit from the dilatory stork. The prospective father wears a green look and the grandparents, though trying valiantly to be gay, appear worn and nervous. They become our heroine's next problem. It must be a first baby, so while passing the coffee and urging a more substantial breakfast, she offers the sympathy she so strongly feels and, for a little added encouragement, touches briefly on her own experience in a similar situation and the satisfactory outcome.

These people out of the way, she flies from one early customer to another. In the meanwhile the dishes pile up and the coffee gets lower.

HERE COME THE VOLUNTEERS

Now it is almost time for the volunteers. Are they coming? If so, how soon and how many? Some shops are not fortunate enough to have any volunteers, which is a real loss. Here they come, only a bit late, apologetic and eager. Now she can be relieved from serving and begin to wonder about supplies and all the rest.

It just can't be ten o'clock and so much yet to be accomplished! A few necessary telephone calls. A worried glance in the icebox, where the tomatoes seem either too green or too soft, a checkup on the meat and a quick marking of cakes and pies. Now it's eleven.

Just as she goes to relieve on the counter, she is waylaid by an attractive volunteer who has found earrings, the kind she has been looking for everywhere, but now she is not quite sure whether they are becoming. A few moments spent over this problem and locating just the right toy for a sick 6 year old, whose frightened mother is at her wit's end to provide for her child's amusement, makes our heroine late on the counter. She apologizes to her co-workers and starts sandwich-making for the luncheon customers.

Suddenly somebody gasps and gives a slight scream. She turns too quickly, almost severing a finger with a sandwich knife, to find that a whole quart of cream has dropped out of a volunteer's hand. She smiles, of course, and wonders secretly about the food cost. More important, did any broken glass get into the food? The mess is finally cleaned up, but not before she and the other worker take a few dangerous and awkward skids on the greasy floor.

Now she is head on in the noon rush. How thrilling to see the people piling in. A rearrangement of chairs and tables is necessary and she wonders deep down inside whether she will have enough food for everyone. Someone reports that the meringue on the soft pie has collapsed. Someone else proclaims the fact that the lettuce is almost out and that the mayonnaise tastes funny. The electric fans are too much for the workers behind the counter and the rest of the shop is stifling. The salads prepared beforehand are gone and she balances the last of the lettuce and a few odds and ends on a plate to take behind the scenes to concoct more. The water from this miscellany of chilled food drips down her smock and stockings, but she feels amply repaid by the grateful smile from a harassed doctor—he likes his salad just the way she made it.

When a tired nurse praises the coffee and literally licks her lips over the layer cake, she takes heart all over again. At last the peak of the rush is over. She feels elated that everyone was served and hopes devoutly that no one guessed the "tizzy" from which she was suffering for a few moments.

A bite of luncheon, interrupted by a few incoming telephone calls and an anxious eye peeled to be sure the late luncheoners are happy and well fed.

Another shift of volunteers and she's off to the afternoon's business. An overly-ambitious, but perfectly swell volunteer decides practically to rebuild the shop and then do a thorough housecleaning job. Our heroine summons all her tact and suggests, though "it's just what we need," it might perhaps wait until later.

Salts and peppers, sugars and napkin holders must be filled. Mrs. Smith wants a certain bedjacket which is in the bottom box on the highest shelf and the pin the little student bought yesterday was broken when she opened the box. The driver of the hospital cart is telephoning down for food orders. No one to send, so our heroine runs up. That excursion over, she races back to the office.

Literally a litter of cartons has been delivered. It must be the new merchandise—what fun! Will it ever get unpacked and tucked away on the already bulging and inadequate shelves?

Her feet begin to ache a bit at this point, so it must be almost time for the night worker. The counter must be cleaned and the porter's day is over.

There is still much to do, however. Such a nice woman left her little boy in the shop for just a second, while she ran up to see grandma who is convalescing. She has been gone for an hour and Junior is getting a wee bit restless. Having consumed several ice creams, he is now attacking lollipops, which his fond mother left to keep him quiet. It's all right as far as our heroine is concerned, except that in spite of sticky fingers, Junior wishes to examine all the books and games within his reach and even contemplates chair climbing to make things more accessible. How really charming children are, or ought to be! In the meanwhile she gets a nice clean towel to sponge this one off. In the midst of this operation in rushes Junior's mamma, all full of apologies, but still a bit upset to find that her child was about to be bathed. As she wishes them a heart-felt good-by, our heroine hopes that he won't have a tummy-ache—at least not much of a tummy-ache.

SUCH NICE PEOPLE

By now she feels that either the spontaneous smile of early morning has frozen on her countenance or that she must have added a dozen wrinkles trying to maintain it, that each step is an effort, that she is sure she must be wearing the wrong kind of shoes. She glances at the clock. The day is over, really quite a successful day, too. As she literally staggers forth on her homeward journey, she wonders how so many people can be so really nice—and she's sure tomorrow will be easier.

Anyone who has done this soul-satisfying job for any length of time realizes that the assets far outweigh the liabilities. To know that the baby expected early in the day is snug in his little bassinet and that some sick children have even had a few moments' amusement over some book or toy of her selection is worth more than any words could ever express. To know that a doctor has laughed with her over some foolishness and perhaps a homesick student has been entertained with a cute stuffed animal or seasonal window decoration and then to know that any money which she may have helped to earn for her shop goes back to her hospital for something necessary for those whose need is greatest—what other job has as much to offer?

WORKERS' IDEAS ARE WORTH THE PRICE

The hospital that starts a money-making work suggestion plan will find that it pays off in improved morale and better service

BYRON TEFFT
Public Relations Director
Methodist Hospital of Southern California
Los Angeles

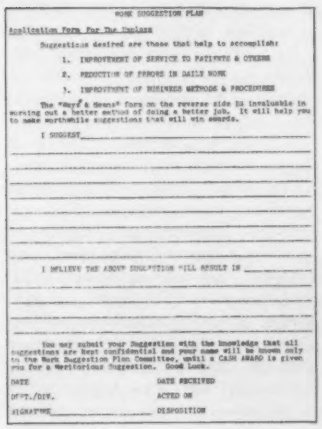
IF YOU were the administrator of a hospital and someone approached you with a bona fide idea which either cut the cost of your hospital's operation by $2500 a year or would provide the same amount in free service through the simple expedient of revamping an existing policy, would you feel it was worth a 10 per cent fee to the individual who proposed it? You would probably jump at the opportunity, at the same time scouting the source for more such suggestions and on the same terms. Most administrators who have already instituted a work suggestion plan system immediately discover that the hospital has just as many sources of business acumen as it has employes.

For example, the administrator who paid a $250 fee to gain a $2500 saving received the suggestion from a nurse who had long been swallowed up by daily routine, but who had finally wearied of being the means of delivery for the daily linens. Her idea for "linen packs"—scarcely a new idea, but nevertheless not in effect in that particular hospital—was like a bolt out of the blue to the administrator.

The nurse's reasoning went something like this: Linen carts normally reached the floors at 8:30 a.m. That day's supply was distributed by the floor supervisor to each nurse for eventual delivery to the patient. This took approximately one hour of the supervisor's time and between seven to fifteen minutes of the nurse's time. It was not always possible to provide fair and equitable distribution of linen to all patients. Briefly, all nurses considered, this consumed a minimum of 955 hours a year at a minimum of $1 an hour for each of three floors; the hospital was spending a total of $2865 for distribution of linen by nurses over a period of one year.

By this time the nurse was warming up to her subject. Under the system she suggested, packs would be made up containing sufficient linen completely to change the average patient's bed with enough left over for Saturdays and Sundays, as well. Next, they should arrive on the floors at 7 a.m. to be distributed by nurse's aides under the direction of the floor supervisor. This would take approximately twenty minutes for each floor, or 365 hours a year for three floors. At a maximum $1 an hour average, it all made a grand total of $2500 a year net saving in favor of the linen pack. Inasmuch as the patient pays for nursing care when he enters a hospital, and the linen pack service left both the floor supervisors and the nurses free to provide it, the payment of a conservative $250 was felt to be warranted by the hospital administrator.

Today, hospitals are striving to improve policies and operating procedures to meet the challenge of inflation. Most have learned from experience that a change in policy, or in the method of doing a certain job, is necessary to continuing solvency. Often these changes spring from the



WORK SUGGESTION PLAN

Application Form For The Employe

Suggestions desired are those that help to accomplish:

1. IMPROVEMENT OF SERVICE TO PATIENTS & OTHERS
2. REDUCTION OF ERRORS IN DAILY WORK
3. IMPROVEMENT OF BUSINESS METHODS & PROCEDURES

The "Ways & Means" form on the reverse side is invaluable in working out a better method of doing a better job. It will help you to make worthwhile suggestions that will win awards.

I SUGGEST_____

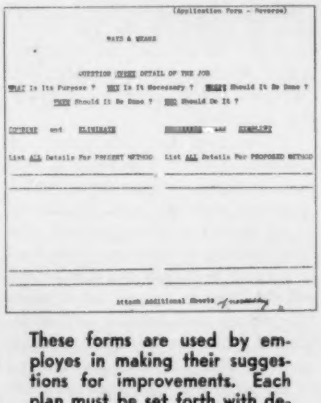
I BELIEVE THE ABOVE SUGGESTION WILL RESULT IN _____

You may submit your Suggestion with the knowledge that all suggestions are kept confidential and your name will be known only to the Work Suggestion Plan Committee, until a CASH AWARD is given you for a Meritorious Suggestion. Good Luck.

DATE _____ DATE RECEIVED _____

DEPT./DIV. _____ ACTED ON _____

SIGNATURE _____ DISPOSITION _____



(Application Form - Reverse)

WAYS & MEANS

QUESTION EVERY DETAIL OF THE JOB

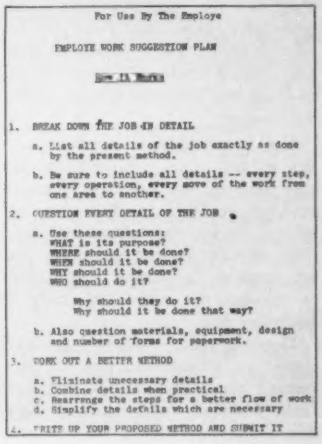
WHAT Is Its Purpose ? WHY Is It Necessary ? WHEN Should It Be Done ?

WHERE Should It Be Done ? WHO Should Do It ?

COMBINE and ELIMINATE RECHANGE and SIMPLIFY

List ALL Details For PRESENT METHOD | List ALL Details For PROPOSED METHOD

Attach Additional Sheets if necessary



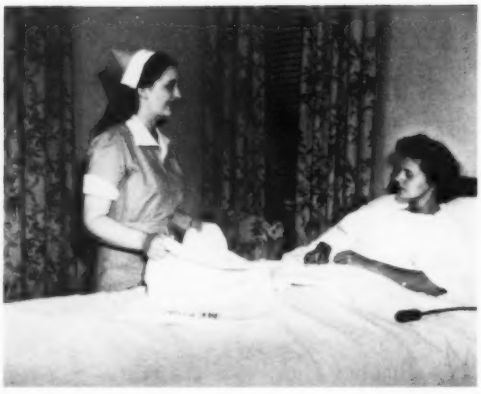
For Use By The Employe

EMPLOYE WORK SUGGESTION PLAN

How It Works

1. BREAK DOWN THE JOB IN DETAIL
   a. List all details of the job exactly as done by the present method.
   b. Be sure to include all details -- every step, every operation, every move of the work from one area to another.
2. QUESTION EVERY DETAIL OF THE JOB
   a. Use these questions:
      WHAT is its purpose?
      WHERE should it be done?
      WHEN should it be done?
      WHY should it be done?
      WHO should do it?
      Why should they do it?
      Why should it be done that way?
   b. Also question materials, equipment, design and number of forms for paperwork.
3. WORK OUT A BETTER METHOD
   a. Eliminate unnecessary details
   b. Combine details when practical
   c. Rearrange the steps for a better flow of work
   d. Simplify the details which are necessary
4. WRITE UP YOUR PROPOSED METHOD AND SUBMIT IT

These forms are used by employes in making their suggestions for improvements. Each plan must be set forth with details of how and why it works.



Below: Five-card "case-assignment" method of providing nursing care has proved more advantageous than the old "functional" method. Registered nurses and others are assigned to a patient for the duration of his stay and receive daily instructions for their care by means of colored cards.

Left: The linen-pack method of distributing daily linens netted the hospital $2500, and the nurse who suggested it, $250. Below: The idea of putting an old table on casters and rolling stock to storage space instead of carrying it by hand was worth $10 to storeroom personnel and saves employes' strength.

limited circle of management. However, it should be remembered that employes are also interested in their jobs and in the progress of the hospital. Their stake is their livelihood and they probably have some constructive ideas about their jobs, or even about the job a co-worker does and how it could be improved—if someone was interested enough to listen to them.

Yet, most hospital managements fail to take into consideration the gold mine of practical on-the-job experience available to them for the asking. By leaving the ore unmined, they provide little opportunity for the employe to correct a situation or improve the method of doing a particular job.

However, the hospital industry should not be taken to task for permitting the talents of its employes to lie dormant. For it has been only recently that the general business picture has cleared sufficiently to give all who cared to look a glimpse of a brand new and tremendously effective industrial public relations technic, *i.e.* the management-sponsored employe work incentive program.

Management and labor have recently perfected a method for single-purpose effort in the same direction. It's a case of the "you-scratch-my-back-and-I'll-scratch-yours" type of reasoning, designed specifically to increase efficiency in plant operation with substantial rewards for both groups. By providing a legitimate incentive for the employe through application of a work suggestion or improvement plan, business in effect notifies the wage or salary earner that its ability to pay a bonus, pension or annuity to the employe depends on the individual employe's ability to improve methods and procedures within the business. This honest and frank approach on the part of the employer begets an equally honest effort to comply on the part of the employe. Meanwhile, the somewhat ruffled feathers of stockholder and consumer public alike are considerably smoothed.

While most hospitals cannot be classified as either a production or a profit business, the purpose of a work suggestion plan can be readily adapted to the operation of any hospital. The only existing obstacle to immediate acceptance is human and not technical; the same as stymied other industries in the beginning, a sort of ingrained belief on the part of management, that: (1) there was nothing to be improved upon, and (2) the employe had nothing further to offer beyond the routine requirements of his job, so why bother? However, with the lesson of bolder spirits as a guide, plus the fact that most of the "bugs" have been worked out, a hospital should discover little difficulty in immediately tapping the reservoir of employe ingenuity.

First off, the work suggestion plan should not be confused with its ineffectual and shopworn predecessor, the "suggestion box." Contrast between the two is basic. The work suggestion plan offers scientific evaluation with a standard percentage payoff, while the suggestion box encourages indiscriminate judging of ideas on a personal plane, with cash payment made on an equally indiscriminate basis. The former is good applied psychology, aiming at the employe's twofold desire to participate with top-level management in policy formulation and getting paid for it at the same time. On the other hand, a suggestion box seems to engender

a fear of reprisal on the part of the employe for criticism of management's existing policies. This is no doubt induced by the attitude of management itself in instituting the suggestion box idea as a concession to the employe rather than as a help to management. It just seems to invite destructive critical statements, incomplete in reasoning as well as tact.

Under the work suggestion plan system, all employes—wage or salary—with the exception of department managers are eligible to submit ideas for the improvement of existing methods and procedures, improvement of service to patients, or reduction of errors or work load. Awards for accepted suggestions are based on either of two principles, both of which are equally effective. The first constitutes immediate cash payment to the individual of what is computed to be 10 per cent of the net savings to the hospital over a period of one year. The second is reckoned on a 15 per cent net saving to the hospital over a period of one year, with 5 per cent paid in cash and 10 per cent invested in a yearly bonus, pension annuity or termination fund —on a profit-sharing basis—for participating members only.

When suggestions are made which cannot be computed percentage-wise, a special cash award would be made to the individual commensurate with the aptness of the idea.

Awards would not be made in cases where the suggestion covers a situation already known to management. For example, a suggestion which simply states that "errors should be eliminated in the business office" is not valid unless it describes *what* errors and *how* they can be eliminated. In addition, awards should not be made for suggestions recommending the expenditure of sums in excess of $100 for capital investment. This discourages the employe who feels that new x-ray equipment, or even a new building, will improve efficiency. However, suggestions to eliminate or add paper forms, utility carts or other items should be looked upon as genuine improvements warranting the expenditure of money, only if the cost does not exceed 50 per cent of the gross saving to the hospital for the period of one year.

The best way for the employe to start looking around for ideas to submit is for management to prepare all the facts and forms to be put before him, meantime indoctrinating department heads to encourage the critical faculties of those under them by calling attention to any job that is currently giving trouble. When an employe submits a suggestion, it should be written on a standard form available from the department head, placed in an envelope and handed personally to the department head.

The work suggestion plan committee, composed of the department heads with the administrator as chairman, should meet regularly to decide the merits of each suggestion. If the suggestion is rejected, the department manager concerned should explain the reasons for the rejection to the employe and at the same time offer him all possible help in improving the suggestion so that it might be submitted for further consideration. However, for the protection of the employe, all rejected suggestions should be kept on file for a period of one year.

Once launched, a work suggestion plan should receive the same care and attention that went into the preliminary groundwork for its introduction. The hospital house organ should not only list the names of winners but should constantly pound home the ease and benefits of participation, stressing the fact that ideas can be old, new or used, just so long as the hospital gets the benefit of worthwhile suggestions.

Such publicity not only encourages the timid to try their hand, but also has a way of spreading throughout a community. It provides a "natural" publicity story for newspapers, giving them a legitimate answer for their criticisms on inefficiency and high costs of operation. In any case, if no other tangible results were gained, the lift in employe morale alone would be worth the price. Constructive thinking has always paid handsome dividends in the past and it has never hurt a bit.

Administrative Capsules

MOST HOSPITALS are too rigid in construction, and their functional development is therefore hampered.

TOO MANY HOSPITALS are poorly located and unevenly distributed.

MOST HOSPITALS limit their interests severely to the acute phases of illness and, therefore, render a bare minimum of scientific service to the community.

MOST HOSPITALS seem continually to be missing opportunities in preventive medicine and in social medicine, yet these are intimate and inextricable parts of the scientific program of any hospital.

POSTWAR PLANNING in hospitals is almost entirely limited to the acquisition of more and more beds, which means bigger but not necessarily better hospitals.

IN A LINGUISTIC SITUATION which is decidedly polyglot, the hospital executive seems forever to be seeking some kind of Esperanto to help him understand the infinite variety of his staff.

TOO MANY HOSPITALS lag behind the economic and scientific trends of the times and seldom lead.

HOSPITALS receive and accept favors from Nature which they seldom credit to the proper source.

TOO MANY PHILANTHROPISTS have strayed from the path of charity and used their bounty for the purpose of self-aggrandizement.

HOSPITAL DEFICITS have a strange power in attracting philanthropic funds—a paradox which no community should tolerate. (It is not enough to save the hospital from financial bankruptcy at the last moment.)

TOO MANY HOSPITALS have encouraged the fetish of professionalism and thereby made costly sacrifices on the altar of standards.

THERE ARE STILL too many hospital executives who exhibit the glass eye of the banker.

TOO MANY HOSPITALS are notorious for missed opportunities.

TOO MANY HOSPITALS are content with "minimum standards."

HOSPITAL ATTENTION is too often diverted from the bedside by the presence of numerous activities within its walls which can safely, if a trifle more expensively, be done somewhere else.

THERE ARE STILL too few prophets in hospital work who are genuine, and the choice of a consultant at critical moments is severely limited as a result.

—E. M. BLUESTONE, M.D.

Control of EPIDEMIC DIARRHEA

is the hospital's responsibility

HERMAN N. BUNDESEN, M.D.
President
Chicago Board of Health

THE record achieved by Chicago's hospitals, which have been free of any serious outbreaks of epidemic infant diarrhea over a period of eleven years, did not occur by chance. Rather, that record has been built on painstaking observance of regulations laid down by the health department in 1937, following careful study of the problem by a committee of authorities in the field of maternal and infant welfare.

In an article last month, I set forth the principal regulations governing personnel in the maternity and nursery departments, equipment of the departments, supervision and procedures to be observed in the care of infants. The remaining regulations to be discussed here include those having to do with physical layout and facilities in these departments, and procedures in connection with the feeding of infants and the isolation of infections and suspect cases.

PHYSICAL FACILITIES

The maternity division should be in a separate building, or on a separate floor or floors, or in a section of a floor completely separated from other divisions of the hospital. The section of the floor should be so located that patients, personnel or visitors from other parts of the hospital do not pass through it.

Every maternity hospital should maintain a nursery for the care of newborn infants. The newborn nursery should be completely separated from all other rooms except the examining or work room of the nursery, the premature nursery, or another newborn nursery. It is desirable to have an anteroom to the nursery in which the physician and other personnel may remove street clothing, put on clean masks and gown, and scrub the hands before entering the nursery.

The delivery rooms shall be in a maternity unit and separate from the surgical and medical departments. When the delivery room is in a separate unit, maternity patients may more easily be kept out of contact with other types of patients and with other possible sources of infection.

The delivery room may be on the same floor with the rest of the maternity division when the maternity division occupies the entire floor. The delivery room may be on the same part of a floor to which the maternity division is limited. If the delivery room is located elsewhere, such as on another floor, it shall be completely separated from all other parts of the hospital.

When the delivery room is on a floor or part of a floor other than where the rest of the maternity division is located, precautions must be taken in transferring mothers and infants. They should be protected from exposure to drafts and chill, and from coming in contact with anyone except the necessary maternity division personnel.

For example, there shall be no visitor or anyone other than the necessary [illegible] and maternity division personnel present when the mother is being transferred to the division.

The delivery room shall be used exclusively for the obstetric care of pregnant, parturient or puerperal women, and for the immediate care of their newborn infants.

Separate labor and delivery room [illegible], with separate equipment, should be maintained for the delivery of [illegible] patients and infectious patients. If the hospital has only one delivery room, some other room, such as a private room or the like, shall be used for the delivery of infectious mothers. During labor and delivery, the mother is especially susceptible to infection. Therefore, every possible safeguard should be taken at this critical time to prevent infection. It is impossible to be sure that after the delivery of an infected patient all infection in the delivery room can at once be completely eradicated. Hence it would be dangerous to deliver a clean patient in a delivery room where an infected patient had been delivered within the last twenty-four hours.

There shall be adequate isolation facilities for mothers having or suspected of having any infection. The isolation quarters shall be completely separated from all other parts of the maternity division. The best arrangement is to have individual isolation rooms. For every twenty maternity beds, there shall be one bed available for isolation. It is to be remembered that no infected obstetric patient should be housed where there is danger of infecting a non-obstetric patient.

Separate isolation facilities shall be available for the isolation of infants having or suspected of having infections. A room adequate for isolating infants having or suspected of having infections shall be available. The isolation nursery may be adjacent to the newborn nursery, but shall not have any [illegible] connection with it or with any other room except its necessary accessory rooms.

FEEDING

Infants should be taken individually to their mothers. When a multiple carrier is used, the infants left in the carrier after one infant is taken to its mother may come in contact with visitors and hospital personnel in the corridor. Furthermore, these infants may be exposed to drafts, and close contact between them may also take place. If a multiple carrier is used,

This is the second of two articles by Dr. Bundesen. The first article appeared in The Modern Hospital, [illegible]

unless proper handwashing facilities are close at hand which make it possible to wash the hands thoroughly after handling each infant, infections in the infants are liable to occur.

When an infant is taken to or from its mother, it should be handled only by the nurse and the mother, placed on top of the covers, and should not be put to the breast in the presence of visitors.

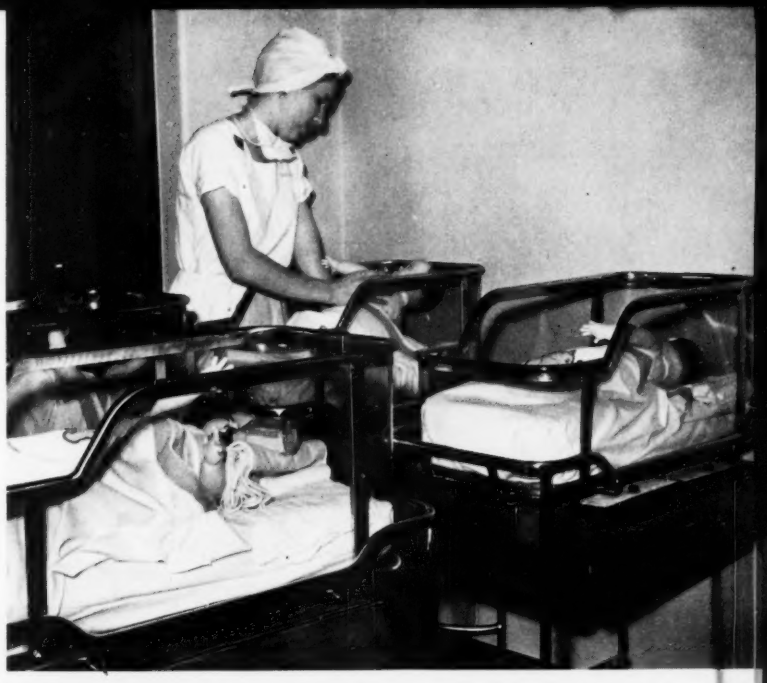
All mothers should wear a suitable jacket, and shall cleanse their hands thoroughly prior to receiving their infants for feeding. Masks shall be used, when indicated, during each feeding, and shall always be clean and effective.

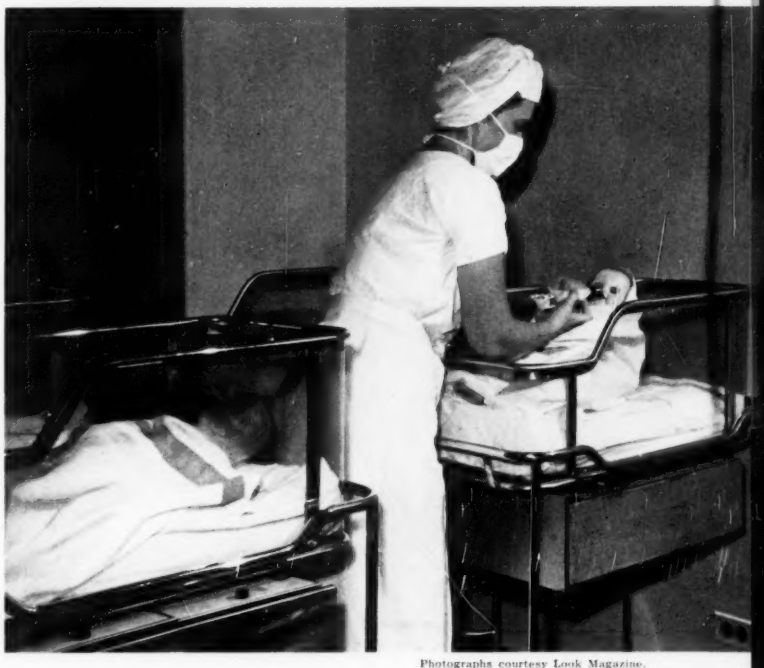
Complemental feedings, when used, shall be prescribed individually, and only by the physician in attendance. It is recognized that the same formula may be applicable to any number of babies. The spirit of the regulation is that no doctor shall prescribe a formula for any baby unless he knows what the formula contains.

The nursing bottle must be held during the feeding. When the bottle is propped up for the infant, the nipple often slips out of the infant's mouth and becomes contaminated. Furthermore, the infant may strangle on the milk. Each bottle-fed infant must be fed individually by the nurse, mother or other suitable person. If the nipple is contaminated, it shall be immediately discarded and another sterile nipple used.

A suitable or separate room shall be equipped with adequate facilities for the sterilization of bottles, nipples, bottle caps and other utensils used in the preparation of formulas and preservation of such food under aseptic conditions. The preparation and handling of feedings must be carried out under rigid aseptic conditions in order to prevent any contamination of the feedings, with resultant infection of the infant. Many outbreaks of infective diarrhea in hospitals have occurred because the artificial feedings were contaminated.

Nurses assigned to formula room duty shall be prohibited from doing any type of duty on septic or infected cases in any part of the hospital during their entire period of service in the formula room. If a nurse prepares formulas, she may also carry out such duties as working in the newborn nursery or aiding in the care of clean, obstetric patients, after she has finished preparation of the formulas. If the nurse preparing the formulas has such additional duties, it is suggested that

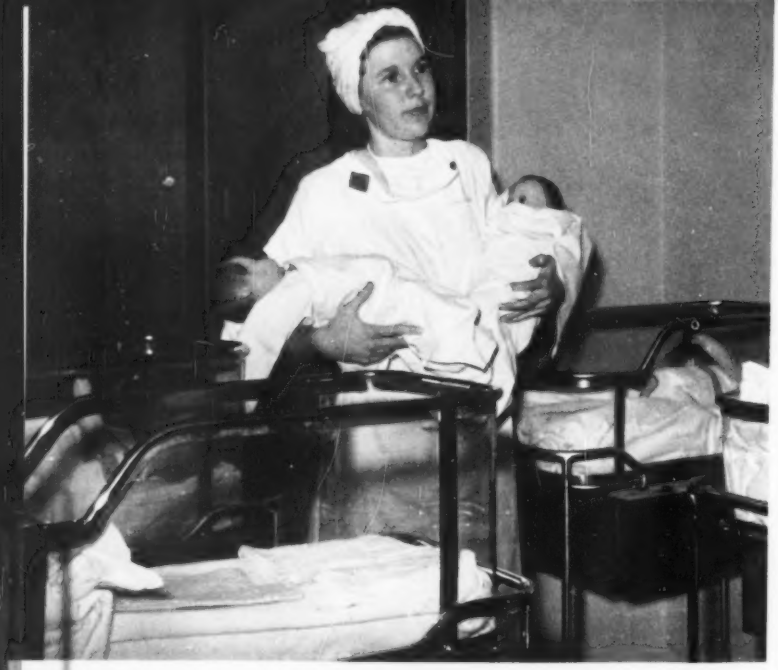


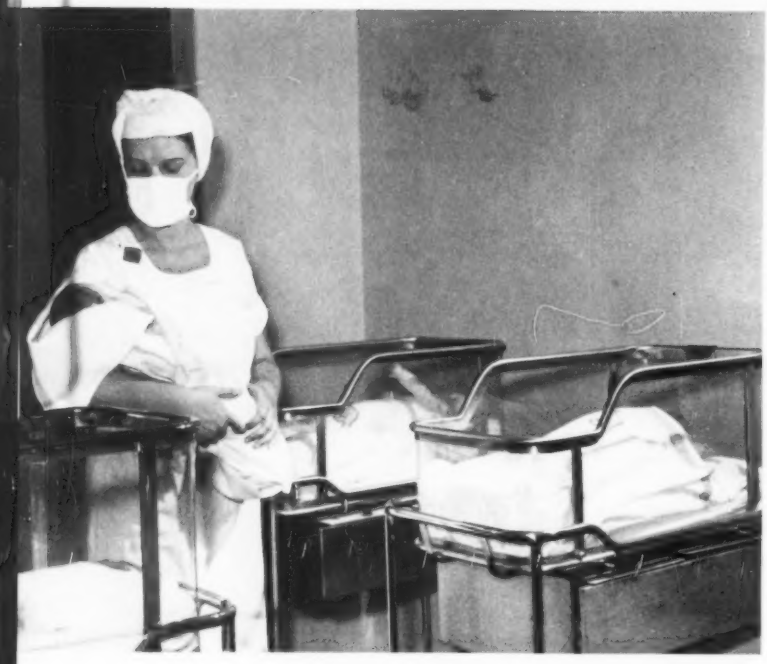


Photographs courtesy Look Magazine.

WRONG (top): Leaving infant with bottle propped up on blanket or pad should be absolutely prohibited! Bottle could easily slip out of place, contaminating nipple or even injuring baby. Babies must be fed one at a time in nursery.

RIGHT (bottom): Here the nurse offers bottle feeding with proper technic. Infant's head is raised to avoid danger of choking when food is taken while infant is lying flat. Nurse is holding bottle carefully to avoid contamination.





WRONG (top): Nurse carrying two babies at same time is violation of proper technic. Babies are not adequately protected by wrap and are being held carelessly. Nurse's cap leaves hair line exposed; mask is removed and dangling.

RIGHT (bottom): Infants should be taken individually to their mothers at feeding time. Nurse here is using proper technic for carrying baby, with her arm supporting baby's head and back. Infant's face is safely protected by blanket.

preparing the formulas be her first daily duty. Anyone preparing or assisting in the formula room in the preparation of formulas for infants shall, before beginning such duties, remove street clothes and carry out hand scrub routine, and *shall* wear clean cap, *effective face mask* and a sterile gown at all times during such duty.

ISOLATION

Any infant delivered of or in contact with an infected mother, and any baby delivered outside of the maternity hospital or readmitted, shall be considered infectious, and shall be isolated on admission. It is preferable to have cubicles in the isolation nursery. Thus, infants with different infectious disorders and infants who have been exposed to infections can be isolated in the same nursery.

To carry out the cubicle plan infants shall be separated by satisfactory partitions. Each infant shall have his own supplies, and individual aseptic technic shall be carried out in handling each infant.

Clean gowns should be kept at the bedside of each isolated infant and should be worn by everyone entering the cubicle or room. Every isolated patient should have individual articles, such as thermometer, wash cloth, basins, towels, nursing bottles, nipples. Any person handling an isolated infant must scrub the hands with soap and water and wash them in a suitable disinfectant after changing the patient, or after having come in contact with the patient.

If the infant has or is suspected of having any infection, he shall be isolated immediately. Infections spread rapidly among infants. Immediate isolation of every infant having or suspected of having an infection is imperative.

Infants developing serious disorders, such as pneumonia, omphalitis, gonorrheal ophthalmia, tuberculosis, erysipelas, florid syphilis, discharging lesions of any type, or communicable disorders, such as whooping cough or smallpox, shall be removed from the maternity division at once.

In case of an outbreak of diarrhea in a nursery, the following routine is required:

1. Isolate all cases of diarrhea from exposed cases, and report them at once.
2. Quarantine the nursery.
3. Set up an auxiliary, newborn nursery for new admissions.
4. Observe all contacts daily until

discharge, and immediately isolate any showing symptoms.

5. Carefully check back to discover any break in the feeding or handwashing technic.

6. Inspect all equipment of maternity service for possible defects. Check each step of the nursing technic, especially how the nipples are put on bottles. No finger should touch anything that goes into the infant's mouth or nose.

7. Take cultures from any possible source of contamination, and from materials coming in contact with the infant.

8. Make repeated cultures from nasal and pharyngeal secretions of all infants and adults in the maternity division, including mothers, attendants and other personnel. Carriers of the usual pathogenic organisms should be excluded and isolated.

There shall be no new admissions to a nursery where the infants have been exposed to a commmunicable infection until the period of incubation has passed, or all exposed infants have been discharged from the nursery and proper sanitary precautions have been taken. Many outbreaks of communicable infections in nurseries continue because the persons in charge do not act quickly. It is often found that unless the nursery is closed to further admissions, infection tends to continue and, if any new infants are admitted to the nursery, they may quickly become infected.

Diarrhea shall be considered to exist when an infant has four or more loose stools in twenty-fours, except in the case of the entirely breast-fed infants who show no other signs of illness and who are gaining weight. Attention is called to the fact that if there is a watery ring around the stool on the diaper, diarrhea is almost always present.

Infective diarrhea shall be considered to be present whenever one or more infants have diarrhea with such other symptoms as fever, severe dehydration, unusual loss in weight, listlessness or toxemia.

No new admissions shall occur in the exposed nursery until all the exposed infants have been discharged and the proper sanitary precautions have been taken.

The proper sanitary precautions are: The walls of an infected nursery shall be repainted or carefully washed, and floors, woodwork, cribs, chairs and all equipment washed with hot water and

WRONG (top): Nurse is leaning across mother's body to put infant in place for breast feeding. Hands and arms are in unnecessary contact with bedclothes, infant's head exposed. Nurse has carried baby from nursery without mask.

RIGHT (bottom): This shows the proper technic for delivering infant to mother for breast feeding. Nurse is wearing mask and cap in place, carrying the baby properly, approaching mother in easiest manner. Baby is safely wrapped.

soap; the room should be aired and sunned, if possible; the mattress covers washed, and the mattresses sterilized by heat, if possible. The nursery shall stand vacant for twenty-four hours after thorough cleaning and renovation, before being put into service again.

Other regulations have to do with the staff in obstetrics, equipment and conduct of the labor and delivery rooms, care of mothers, circumcision of male infants, handling of laundry and control of water supply, ventilation, noise, odors and vermin. Nurses and doctors on the health department staff are instantly available for consultation with hospitals in connection with observance of the regulations or any other problem arising in connection with the operation of the maternity and nursery departments. In addition, every hospital is inspected every ten days, or oftener if it is judged necessary, to make certain proper technics are being followed throughout. Our feeling is that no detail of the procedure can be overlooked or neglected; a tiny break in technic could result in a major threat to the lives we are all responsible for protecting.

When doctors, nurses, hospital and public health authorities everywhere approach this responsibility with the conviction that no departure from rigid technic can be tolerated, epidemic infant diarrhea will soon be eliminated as a menace to the safety of hospital nurseries.

Comparisons prove the value of

OCCUPATIONAL THERAPY *in the Tuberculosis Hospital*

THE indispensability of a good program of occupational therapy must be proved through controlled experiments before the service is granted financial support sufficient to provide for an excellent staff and an adequate supply of materials and tools.

Only through a carefully conducted series of planned comparisons can occupational therapy be validated, its true worth be known, its benefits universally accepted, and its indispensability proved. While there are some who are aware of the benefits to be derived from occupational therapy, there remain many to whom this approach is unacceptable on the grounds that it has not been validated scientifically.

In an article on "Occupational Therapy in Pulmonary Tuberculosis" (*Occupational Therapy and Rehabilitation*, June 1948), Dr. Sidney Licht proposes the following comparisons which, when evaluated, would in his opinion validate occupational therapy:

Prove that occupational therapy keeps the patient in the hospital longer by one of three methods:

1. Compare the duration of hospitalization in any one hospital of those patients not participating in occupational therapy with that of those who do.

2. Compare hospitalization periods of patients in several hospitals which depend on occupational therapy with those of patients in similar hospitals which did not have this program.

3. By a controlled experiment, provide unselected alternate patients with occupational therapy over a suitable period of time, and compare their hospitalization with that of the remainder of the group not receiving occupational therapy.

The author objects to the last plan as being too strict a program. In this plan, many who feel no need for occupational therapy would be forced to partake of it, and those who wanted it would have to be deprived of its benefits. However, the first two plans can prove by means of bookkeeping and observation what was set out to be proved, and the varied needs of the patients can be met through the experiment. It is important that this varied patient response be considered in the analysis of this experiment.

Prepare a method for prescribing occupational therapy on the basis of (1) physical effort, (2) time consumed, and (3) energy consumption.

1. Each craft should be analyzed in terms of type of motion necessary to complete the project, and only those crafts which require a minimum of physical effort will be approved.

2. The average time consumed by a heterogeneous group of patients for the completion of any one project would be used as the basis for a time factor—an approximation most necessary in the evaluating a time dosage.

3. Energy consumption can be measured by metabolism tests on members of the staff completing the same project while reclining.

By this experiment, progressively graded work can be prescribed to the patient.

A measurement of relaxation, contentment, and the diminishing of anxiety, accomplished by an occupational therapy program, can be obtained to some extent by electromyography and psychological testing.

These methods of measurement entail some expense and it will be necessary that this objective remain conjectural until it has been scientifically appraised.

The author also mentions the following:

1. Occupational therapy can play an important part in the patient's total rehabilitation program. It can assist the vocational guidance counselor in a choice of a new work objective for the patient whose previous occupation is no longer feasible for him in the opinion of the staff.

2. Occupational therapy also is used as a parallel treatment for surgical patients who are also receiving physical therapy. With medically prescribed kinetic occupational therapy, the amount of deformity is considerably lessened.

3. A moot question—the sale of finished products for chronic patients—is mentioned, inasmuch as many of the problems of occupational therapy in tuberculosis hospitals are dependent upon the hospital budget.

It remains to the future that what many already accept as fact will be proved: Occupational therapy is indispensable in a tuberculosis hospital.—DOROTHY A. SEBESTA, O.T.R. *Montefiore Hospital Country Sanatorium, Bedford Hills, N.Y.*

A parent speaks out for

PARENT TRAINING CLASSES

JEAN A. LYONS
Grand Rapids, Mich.

THE patient in labor was calling for someone—not her husband, or the doctor, or even the clergyman. She wanted an instructor in parent training!

It seems the patient had overlooked preparing little Junior at home for the advent of his baby sister or brother. Now she found herself with both feet in the midst of a hopeless jealousy problem, even before the baby's arrival.

This patient in Butterworth Hospital, Grand Rapids, Mich., knew that the hospital was providing an educational program of information and inspiration for its maternity patients. She simply could not wait to join the class to have a qualified instructor help her thresh out her troubling problem.

I know what these classes mean to the mothers of Grand Rapids. I was recently a maternity patient in Butterworth myself and attended the classes for maternity patients.

The Butterworth program had its beginnings with the vision and keen perception of the director of nursing. It was spurred by the cooperative efforts of the hospital superintendent and obstetrical staff.

HEALTH INSTRUCTOR ADDED

The program swung into action when a special employe was added to the staff to integrate health instruction as an educational function of the hospital. Before becoming an army nurse, she had been a public health nurse with the city health department. The director of nursing had had extensive experience in teaching in prenatal clinics. Together, the two women made an ideal combination for the creation of a really worthwhile educational program for new mothers.

I need not go into lengthy detail about the operation of the plan. Briefly, this is the standard practice: We were escorted each day by a student nurse to the elevator and up to the gayly furnished solarium on the top floor. Here we eased ourselves into roomy, cushioned chairs in an informal, folksy circle.

These were not "classes," mind you. Instructors referred to the meetings as group discussions, preferring to conduct them as an informal sharing of ideas, experiences and knowledge on the part of mothers and teachers alike.

It was my impression that much depends upon the type of instructor chosen for this work. Every mother of a tiny, new baby, no matter how many times she has been a mother, is always awed by the feeling of responsibility for the new little life she has just brought forth.

Some are bewildered and even frightened at the prospect of caring for the fragile little bit of humanity.

One 19 year old patient confided in me: "I married my husband while he was in an army camp. All of my relatives are far away in the South. We are strangers here. I had no one to turn to for help and advice. These instructors will never know how grateful I am for their sympathetic understanding and helpfulness."

On Mondays and Fridays the mothers meet with a staff member of the Grand Valley Children's Center, influential Grand Rapids agency for aiding maladjusted children. This instructor emphasizes the importance of recognition of the emotional and mental side of human make-up, as well as the physical. She stresses the child's need of basic emotional affection and love and stimulates understanding of the truly desirable characteristics of an ideal parent-child relationship.

On Wednesdays, a member of the staff of the Grand Rapids Public Library who is the hospital librarian reviews approved books and magazines on baby care. At the close of her talk, she visits every mother on the maternity floor. She lends government booklets on child care to those interested and leaves with each mother a postal card bearing the names of material available free of charge from Washington. The mother may check the material she desires, mail the card, and the booklets will be sent to her home.

The hospital recommends as one of the finest child care books available a volume which now retails at only 25 cents. As a courtesy to the many mothers who are eager to obtain the book upon learning of its importance, the librarian maintains a supply which is made available to patients at cost.

On Tuesdays and Thursdays, discussions are led by an instructor in public health nursing, with special training and background in parent education and child guidance. Her talks have to do with fitting the baby into the family emphasizing the psychological implications, and with general health aspects.

DISCUSS WHAT INTERESTS THEM

Discussions follow no set pattern. Interest may center one day on thumb sucking and toilet training, another day on arguments for and against a rigid schedule, still another day on problems involved with a jealous older child. Such flexibility of thought, subject to the interest evidenced by the group, results in genuine help on the real and present problems which the new mothers face or expect to face.

During the last year, 2640 deliveries occurred in Butterworth Hospital. Almost without exception, these mothers were eager to attend the discussion groups. By no means were the classes composed only of mothers having their first babies. Mothers with large families were just as eager to attend as were the new initiates. One mother of twelve youngsters declared she had received much help from the discussion, while she, in turn, had much to offer from her wealth of experience.

Probably two-thirds of the patients admitted have heard enthusiastic reports from friends and express eagerness to take part. These classes have attracted women from all walks of life, rich and poor alike, educated and uneducated. There have been several charming war brides, struggling with learning the American language.

Most communities are providing prenatal classes and other types of courses for parents. These are not reaching enough of the mothers. Busy mothers, no matter how much they may realize their need, find it difficult to attend class sessions of any type after taking their babies home. Holding the classes while the mother is a patient in the hospital assures far greater response.

Butterworth instructors have found that the program not only has helped the mothers in the problems which will arise with the new babies, but also has created an awareness of possible deficiencies in dealing with older children at home. In several cases, specific problems have resulted in a direct referral to the Grand Valley Children's Center for professional aid.

A good barometer for measuring the influence of the classes is the pronounced increase in the demand at the public library for books which the librarian has reviewed and recommended. Moreover, without any attempts to "sell," within the first few months she placed more than 1000 copies of the recommended 25 cent volume on child care in the hands of new mothers. Some mothers, she adds, have even come into the hospital with a copy of this book in hand, thinking to use it as a sort of textbook during the class sessions!

When early ambulation for maternity patients first went into practice, the maternity hall presented considerable of a traffic problem at Butterworth. Patients wandered about aimlessly or strolled to the nursery to admire their offspring through the glass. The classes now present a welcome interlude in the day's routine for the patient and give her an opportunity to spread her wings without interfering with regular hospital traffic.

Butterworth is pleased and proud of its pioneering efforts in this educational program for new mothers. The enthusiasm of mothers who have benefited by the activity is deeply gratifying to the administration.

For the sake of mothers-to-be in other communities, I sincerely hope that all forward looking hospitals will soon adopt this important activity as a part of their service.

What are the rewards? As yet there is no way to measure the results of this program, no startling figures to point to and draw public acclaim. The answer may be written in your community's record of child health and juvenile delinquency, ten or fifteen years from now.

The time to reach the mother is definitely when Baby first sees the light of day, for then the mother is at the peak of emotional receptiveness. Twice I have stood at that peak, hungry for expert guidance. My gratitude goes to the far-sighted hospital staff which supplied this need.

EARLY AMBULATION COSTS LESS

GEORGE L. DAVIS
Executive Director
Nassau Hospital
Mineola, N.Y.

THE advancement in medical science and the improvement in hospital facilities and equipment have brought about earlier ambulation of hospital patients and a corresponding reduction in the period of hospitalization. The greatest single factor in shortening the hospital stay of medical patients has been the introduction of the antibiotics: sulfadiazine, penicillin and streptomycin. Many bacteria are sensitive to one or another of these substances, and it is now almost a routine procedure to make a culture of the organisms in the blood or sputum of a pneumonia patient, for example, to determine which of the three antibiotics will kill the organism in the laboratory, and then to prescribe the proper one, resulting, usually, in a reduced hospital stay.

Ten years ago cases of thrombophlebitis were treated by bed rest which often lasted for weeks. These cases are now treated with heparin. The usual period of treatment is five days; during three of these the patient is ambulatory, and at the end of the treatment the patient is discharged from the hospital and usually has no recurrence of the ailment.

It is impossible to state exactly how much a patient's hospital stay has been reduced by timely use of oxygen. Ten years ago oxygen was used only in very serious cases and often as a last resort, whereas now it is used on the slightest indication that there is an oxygen need.

Another major factor that has brought about the shorter hospital stay of certain cases is the changed attitude which physicians have taken toward bed rest. Only a few years ago maternity patients were hospitalized for from ten to twelve days and were required to remain in bed almost the entire stay. Today, maternity patients, in practically all cases, are allowed out of bed on the second day postpartum and are discharged from the hospital from five to seven days after admission.

This early discharge is not because there is a dearth of maternity beds as many people still believe. During the bombing of London in 1940 and 1941 shelter was at that moment of the utmost importance. Maternity cases sought safety soon after delivery and were discharged from the hospital after a short stay with no ill effects. A study was made by Dr. J. Edward Hall, Brooklyn Hospital, of early ambulation of 377 consecutive and unselected private obstetric patients treated from May 21, 1944, to June 30, 1946. All of these patients manifested well-being.

I am told that in surgery, complications are possible owing to sluggish circulation as a result of the patient's being kept absolutely quiet in bed for prolonged periods after the operation. This is particularly true in older people whose circulation often is none too good before the operation. Now many surgical cases are allowed out of bed on the third or fourth postoperative day instead of on the twelfth or fourteenth. Therefore, cases formerly hospitalized for two or three weeks are now discharged much earlier.

Now just what has this great ad-

vance in the care of the sick and injured contributed to their welfare besides shortening the hospital stay? It has proportionately shortened the physical and mental discomfort of those hospitalized. Furthermore, it has reduced the hospital cost because of the shorter time the patient is hospitalized, so that relatively speaking "case costs" have not increased in direct proportion to the increase in the cost to the hospital for salaries, supplies and materials. In fact, in a few instances, owing to the shorter hospital stay, the "case cost" is less now than it would have been ten years ago. Even though the cost for the shorter stay cases may be greater today than previously, because the hospital has found it necessary to increase its charges to the patients, it is certain that the increased hospital bill is offset by a factor we must not forget—the patient is returned to his normal earning capacity earlier.

The operating expenses of the hospital have kept pace with the rise in the cost of all essential materials. Some items have tripled in cost and practically all of them have doubled. It was in November 1938 that we first fired the boilers of our new power plant, changing from a solid fuel to oil. The oil purchased then cost $0.0346 per gallon whereas in January 1948 that same grade of oil cost $0.104 per gallon, an increase of 300 per cent. This holds true with many items purchased in large quantities, a few of which are listed in table 1.

To give an idea of the increased cost of operating the hospital, a brief comparative statement of expenses is submitted in table 2.

An analysis was made of a large number of medical and financial records of patients cared for in 1938 and in 1947, according to five different diagnoses believed to have benefited by a shorter hospital stay, to determine the average stay and the average cost per patient stay. The results are shown in table 3.

In the analysis of the patients' accounts the free cases and the part-pay cases were eliminated and the private pay cases were analyzed separately from the semiprivate cases. The results are shown in table 4.

The foregoing analysis substantiates the contention that in many instances patients do not pay much more now than they did ten years ago for their hospital care and that the income to hospitals per patient, per hospital stay, has not increased in direct ratio to the cost of operating the hospitals.

The shorter stay makes available accommodations for more patients, and admitting more patients results in greater use of the several service and diagnostic facilities of the hospital. To bring about greater use of such facilities, the hospital must gear itself to a more rapid turnover of the patients treated. This procedure results in more revenue for the hospital and at the same time reduces the unit cost, thus keeping to a minimum the cost of hospital care to the patient.

TABLE 1—COMPARISON OF COSTS OF QUANTITY PURCHASES

Article	*Unit*	*1938*	*1947*
Adhesive—2 inch	rolls	$ 1.10	$ 2.85
Plaster of Paris bandages	dozen	1.70	3.60
Needles—24 gauge—⅝ inch	gross	6.70	18.00
Gauze sponges	case	5.60	28.65
Crutches	dozen	5.10	14.05
Sheets—63 inch by 99 inch	dozen	7.89	24.48
Pillow cases	dozen	2.11	6.60
Wash cloths	dozen	0.47½	1.26
Soap	pound	0.06⅜	0.19
Tray covers	per M	1.79	2.79

TABLE 2—COMPARATIVE STATEMENT OF EXPENSES

	1938	*1947*
Salaries and wages	$235,513.00	$ 606,473.00
Other expenses	165,294.00	392,164.00
Depreciation	40,727.00	52,233.00
Total expenses	$441,534.00	$1,050,870.00
Patient days	54,925	77,516
Per diem cost	$8.04	$13.55

TABLE 3—AVERAGE NUMBER OF DAYS OF HOSPITAL STAY

Diagnosis	*1938*	*1947*
Normal delivery	11.00	7.70
Cesarean section	13.96	10.76
Appendectomy	11.16	7.86
Herniorrhaphy	14.97	10.60
Pneumonia	13.23	7.20

TABLE 4—AVERAGE AMOUNT CHARGED PER HOSPITAL STAY

	PRIVATE		*SEMIPRIVATE*	
Diagnosis	*1938*	*1947*	*1938*	*1947*
Normal delivery	$115.55	$158.40	$ 89.13	$110.36
Cesarean section	155.05	231.22	113.92	168.08
Appendectomy	149.46	149.55	87.03	89.80
Herniorrhaphy	137.70	173.78	102.83	120.78
Pneumonia	171.50	146.96	115.75	96.87

"As the Twig Is Bent"

ORIENTATION COURSE

Directs high school students' interests toward the hospital

L. WILLIAM COON
Superintendent
Brooks Memorial Hospital
Dunkirk, N. Y.

OFTEN, those of us who are superintendents of nonteaching hospitals have a definite feeling of guilt when we employ the finished products of our sister hospitals, whether they are nurses, technicians, librarians or dietitians. We do not feel that we have done our part in the recruitment or training of hospital personnel. Perhaps, as has been intimated, we really are parasites on the available supply of trained hospital workers.

In this regard, I believe that the national student nurse recruitment program, which provides for financial participation by the nonteaching hospitals, is an excellent idea. It gives all of us an opportunity to support this necessary function.

LOCAL SCHOOLS COOPERATE

As a nonteaching institution, we felt there was some contribution we could make to the general recruitment program, and have begun a "Hospital Orientation Course" in cooperation with the local schools. The course is open to those students who feel they might be interested in a hospital vocation and would like an opportunity to see the actual workings of the various departments and also to discuss a particular vocation with the individual department head.

We have received 100 per cent cooperation from the local school in the screening of applicants and planning the subject matter to be covered. The school vocational guidance director also attends the meetings with the students when discussions are held.

The students in our first groups came to the hospital each school day during the first morning period (8:45 to 9:30). The first day was devoted to a discussion of our own hospital organization chart which was drawn for them on the blackboard in the conference room. In addition, the executive secretary of the Y.M.C.A. talked to the group about the desirability of selecting a vocation as early as possible. He also pointed out the many other factors to consider when choosing one's life work, such as suitability of temperament, the education necessary and the cost of this education, and the monetary return for the services.

On the second day, the president of our medical staff again discussed the hospital organization and its various vocations, this time from a medical point of view.

The third period was devoted to showing a home-made movie which runs about forty-five minutes. This picture was centered about a routine admission, showing the patient coming to the hospital and going through the admission department, taken to her room and put to bed, the routine admission orders being carried out by the nurses, the laboratory girls taking their blood specimens for examination. The next morning our patient has a basal metabolism test and also an x-ray series. Later, she goes to surgery and, while she is convalescing, the other departments of the hospital are pictured. Our patient finally is discharged and is shown leaving the hospital. This movie was taken primarily to show various clubs and organizations the actual workings of the hospital. Some of our employes doubled as patients for the pictures.

On the fourth day of the course, the students began visiting the various departments of the hospital, spending a period in each. These departments included the obstetrical department, general floor units for medical and surgical patients, pediatrics, dietary, pharmacy, laboratory, physical therapy, general business offices, surgery, x-ray, x-ray therapy and the record room.

On the last day (end of the third week), a general discussion of all departments afforded the students the opportunity to ask any questions that had arisen. We also asked them to fill out a short question blank regarding the course, the answers to which have been a guide to us in planning for the later groups.

All of the students so far have been well pleased with the opportunity given them and the results have been most satisfactory. It has helped a good many of them to decide definitely on a hospital vocation. And, what is just as important, it gives the student, who has been definitely planning on a nursing career for example, a chance to observe at first hand what a nurse actually has to do. There is always a possibility she will change her mind and decide against nursing, but I can think of no better time to do so than before she actually has begun her training.

DEPARTMENT HEADS LIKE IT

We have found that our department heads really enjoy the opportunity to discuss their work with these young people. The number in each group is limited to twelve so that it is more personal and affords time to answer everyone's questions. And, as it takes three weeks for a group of students to complete the course, only one hour of any one department head's time is given every three weeks.

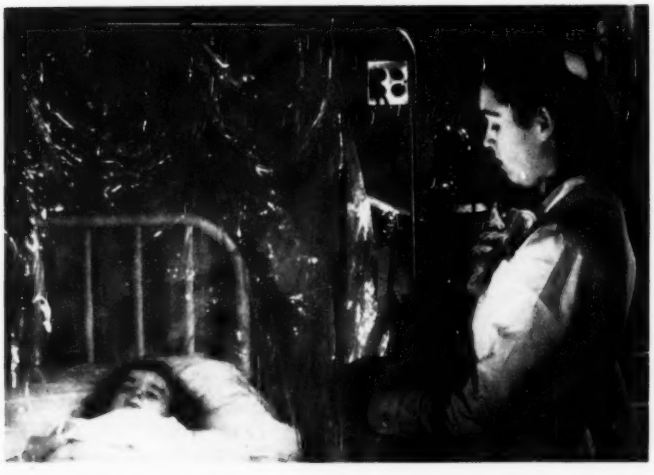
This program was begun as an experiment to ascertain its value to high school students. It has been so well accepted by the students, and so highly praised by the school officials, that we plan to offer the same opportunity to students in neighboring towns as soon as all interested local students have completed the course.

Dallas County Hospital Council presents its annual award to the citizen who has contributed most to the health of the community. Right: Plaque went to Ernest L. Parks, founder of the Diabetic Trust Fund. Boone Powell made the presentation. Left: Special award to Mr. and Mrs. T. L. Bradford for the gift of their home to the Pilot Institute for Deaf Children, Dallas.

Display set up in the lobby of Shadyside Hospital, Pittsburgh, showing how Allegheny County hospitals serve the community. Left: Administrator William E. Barron and (right) Dr. M. A. Cambest, head of the hospital's department of anesthesia.

Acme Photograph.

Dr. Rollo E. Dyer (right), director of the National Institutes of Health, receives American Pharmaceutical Manufacturers' Association award from Dr. Ernest E. Irons, president-elect, American Medical Association.



Scene from "Girls in White," documentary film of the nursing profession. The film traces the training of a student nurse from the time she enters nursing school as a nervous probationer, carries through her preclinical training and the "capping" ceremonies up her graduation three years later and final decision to specialize in pediatric nursing. The film was produced by RKO Pathe Pictures. The American Hospital Association assisted with the preparation of the script.

GARBAGE By Any Other Name . . .

must still be disposed of

IN A survey of garbage disposal methods in small hospitals it was revealed that the average institution today has a centralized garbage collection and dishwashing system, burns the greater part of its garbage in a hospital incinerator and has the remainder picked up by the regular city garbage collection service. Variations from these practices were noted throughout the survey, but they are plainly the prevailing methods used in small hospitals today.

Twenty-four hospitals ranging from twenty-five to 125 beds were covered in the survey. The hospitals were located in all sections of the country and no significant variation in practice from section to section was noted; however, hospitals in rural areas are able to dispose of garbage by giving or selling it to near-by farmers for feeding to swine—a method not commonly available to metropolitan institutions.

While there was no correlation of garbage disposal method and type of building, it may be interesting to note that three hospitals in the group were one-story buildings, eleven occupied two stories, nine, three stories, and one, five stories.

Sixteen of the hospitals surveyed centralize garbage collection and dishwashing operations in one location, trucking waste from this central location to the incinerator or disposal area in galvanized iron cans. Eight hospitals have garbage collection points on the hospital floors in a decentralized collection operation. Information in the survey did not reveal any advantage in the decentralized system.

In any disposal method a major operation is the cleaning of garbage cans after use. In this group of hospitals only four use live steam in the cleaning process; the remainder scrub the cans with soap and water. Many also use saponated solution of cresol and some hose out the cans with hot water under pressure.

Not a single hospital in this group refrigerates garbage at the central collection point as a means of controlling odors prior to final disposal. Several methods of controlling odor at the disposal point were noted—frequent pickups (from one to four times daily) and careful supervision to make certain garbage cans have tightly fitted lids are the methods most commonly used. One or two hospitals use deodorants and disinfectants in this area as an extra precaution and one or two administrators said frankly that the problem of garbage odor was not being solved satisfactorily.

Fifteen hospitals in the group incinerate some of the kitchen waste, one hospital reporting that all garbage is burned. Nine of these fifteen hospitals have incinerators built and installed by a company specializing in that type of service. "Building an incinerator in case one was not a part of your original structure is not a job for the local handyman," one observer commented. "It requires careful planning by architect, administrator and engineer. The services of an installation engineer especially trained in the field of waste disposal are essential. Clearance with local health and fire department authorities in advance of construction is also necessary. In the majority of cases, the existing heating plant chimney can be utilized without the necessity of building a separate stack."

The last point is verified in the experience of about half the hospitals in this particular group. Seven indicate that the incinerator was connected with the central boiler plant smoke

GARBAGE DISPOSAL METHODS IN SMALL HOSPITALS

Region	Beds	Central Collection and Dishwashing	Method of Cleaning Cans	Use of Incinerator	Final Disposal
East	60	Yes	Steam	Part	City
	55	No	Scrub	Part	Scavenger
	77	No	Scrub	Part	City
Midwest	80	Yes	Scrub	No	City and Farm
	50	Yes	Steam	No	City and Farm
	76	Yes	Steam	All	
	86	Yes	Scrub	Part	Farm
	50	No	Scrub	No	City
	46	Yes	Scrub	No	City
South	36	Yes	Scrub	No	City
	75	Yes		Part	Farm
	86	No	Scrub	No	Hospital Truck
	30	Yes	Scrub	No	City
	47	No	Scrub	Part	City
	75	Yes		Part	Farm
	30	Yes		Part	City
West	105	Yes	Scrub	Part	City
	41	Yes		Part	City
	115	Yes	Steam	No	Scavenger
	40	Yes		Part	Farm
	35	Yes		Part	Farm
	25	No	Scrub	No	Farm
Canada	125	No	Scrub	Part	City
	119	No	Scrub	Part	City

stack while the remaining hospitals with incinerators had separate stacks. Several of the hospitals in the group also have auxiliary firing equipment installed in the incinerator for standby purposes—usually for use in unfavorable moisture conditions. An auxiliary boiler is recommended by most engineering services.

Final disposal of garbage in an incinerator on hospital property varies according to location and type of community. Twelve hospitals in the group use a regular city garbage disposal service. Two hospitals employ a private commercial scavenger who is paid for daily garbage pickups. One hospital volunteered the information that this service costs $15 a month. In one case the hospital has contracted with a scavenger service which picks up garbage in cans twice a day, cleans and disinfects the cans before returning them and sprays out the garbage storage bin at the hospital.

GIVE OR SELL TO FARMERS

Six hospitals in rural areas dispose of garbage by giving or selling it to near-by farmers for use as feed for swine. In most cases the hospital gives the refuse away; however, one or two indicate that it is sold and one price of $2 a load for four weekly loads is stated. One hospital trucks garbage in steel drums from the hospital to the city dump in a hospital operated truck and in two institutions some garbage is picked up by the city collection service and some is given or sold to farmers.

None of the hospitals in this group uses equipment designed to grind down kitchen waste. However, one authority suggests that this method might offer possibilities for economy under certain circumstances and is certainly worth investigating.

"Wet garbage can be greatly reduced in bulk by using equipment designed for washing food waste and eliminating water content," it was explained. "This process reduces needed storage space, incineration time or trucking time—depending upon the local disposal method. Moreover, garbage grinding equipment now being marketed has some advantages of convenience in certain circumstances. Certainly, if tray wastes, vegetable wastes and other soft materials are disposed of in this manner, the bulk and moisture problems would be materially reduced. However, opinion is divided as to the application of this method in the hospital field."

What to say and what not to say

When The Press Wants Information

A NUMBER of years ago the Cleveland Hospital Council, working with the Academy of Medicine and local newspapers, formulated a set of rules governing the circumstances under which hospitals can give information to the press, and the nature of the information to be released. Notably because it recognizes the frequently overlooked fact that newspapers as well as hospitals are community agencies with responsibilities to the public, the Cleveland Code has worked successfully for all concerned.

Shortly after it was drafted, the Code was published in The MODERN HOSPITAL. In response to numerous requests from readers, we are publishing it again here, in the form in which it is now being distributed by the council.

—THE EDITORS.

GIVING INFORMATION TO THE NEWSPAPERS

This procedure for giving information to the newspapers has been approved by the member hospitals of The Cleveland Hospital Council, The Academy of Medicine of Cleveland, and the newspapers.

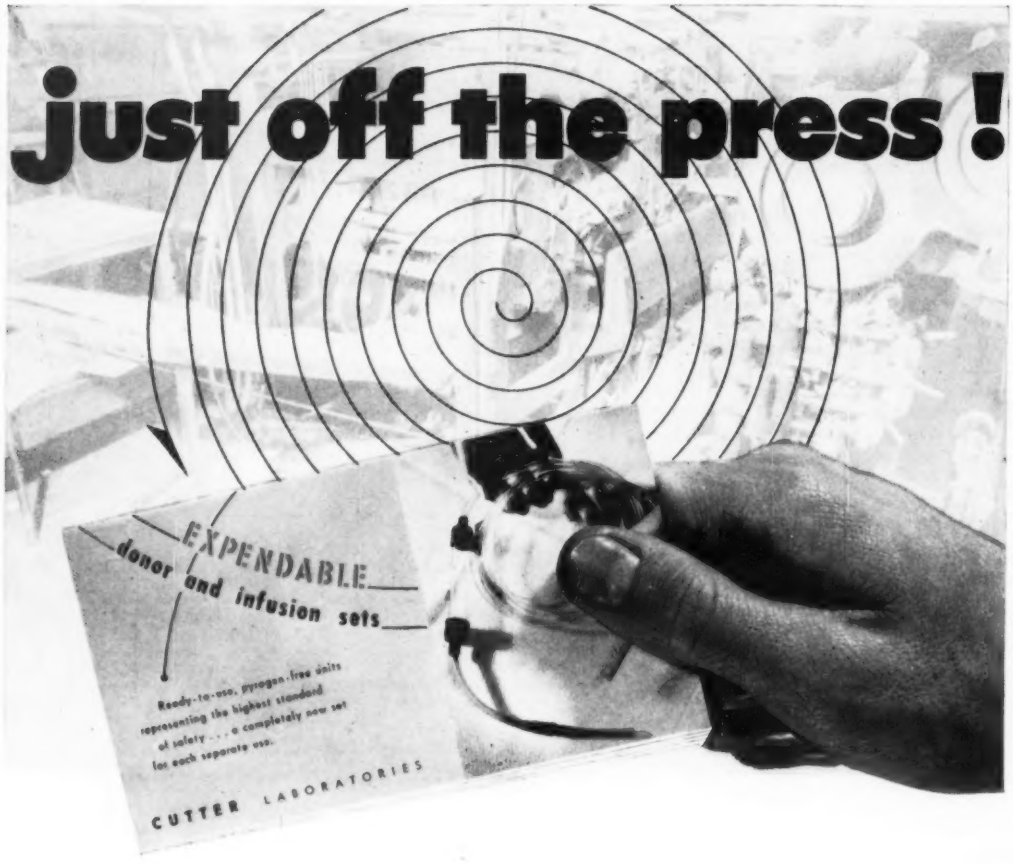
It has been agreed that each hospital administrator should delegate to some person or persons in his organization, authority to discuss with representatives of newspapers, information about patients as outlined in the following procedure.

FOR POLICE CASES the following items of public information may be given without the patient's consent:

1. Name: (a) Married or single, (b) color, (c) sex, (d) age, (e) occupation, (f) firm or company employing patient and (g) address.
2. Nature of the Accident: (a) Injured by automobile, explosion, shooting; (b) if there is a fracture, it is not to be described in any way except to state the member involved, and (c) more than a statement that it is simple or compound may not be made.
3. Injuries of the Head: (a) Simply a statement that the injuries are of the head may be made; (b) it may not be stated that the skull is fractured; (c) no opinion as to the severity of the injury may be given until the condition is definitely determined, and (d) prognosis is not to be made.
4. Internal Injuries: (a) it may be stated that there are internal injuries but nothing more specific as to the location of the injuries, and (b) a statement that the condition is very serious may be made.
5. Unconsciousness: (a) If the patient is unconscious when he is brought to the hospital, a statement of this fact may be made; (b) the cause of unconsciousness, however, should not be given.
6. Cases of Poisoning: (a) No statement is to be made that a patient is poisoned; (b) no information as to kind of poisonous substance, such as mercuric chloride, phenol or carbon monoxide may be given; (c) no statement concerning the motive, whether accidental or suicidal, may be given, and (d) no prognosis may be made.
7. Shooting: (a) A statement may be made that there is a penetrating wound; (b) no statement may be made as to how the accident occurred, i.e. accidental, suicidal, homicidal or in a brawl, nor may the environment under which the accident occurred be given.
8. Stabbing: The same general statements may be made for stabbing as for shooting accidents.
9. Intoxication: No statement may be made as to whether the patient is intoxicated or otherwise.
10. Burns: (a) A statement may be made that patient is burned, also the member of the body involved; (b) a statement as to how the accident occurred may be made only when the absolute facts are known, and (c) no prognosis may be given.
11. Attending Physician: Hospitals may state to the representatives of newspapers, the name of the attending physician of private patients and refer such representatives to the physician for information about the case, but the newspapers shall not use the name of the physician without his consent.
12. Pictures: When newspapers request the privilege of photographing a patient in the hospital, such permission will only be given (a) if in the opinion of the doctor in charge of the case, the patient's condition will not be jeopardized, and (b) if the patient (or in the case of a minor, the parents or guardian) are willing to have a photograph taken.

FOR OTHER THAN POLICE CASES the following rule has been adopted: "If the patient is conscious and can communicate with the doctor or nurse in charge, or relatives, he should be asked whether he will permit any information to be given and his decision is final."

If the patient agrees to permit information to be given the conditions are identical with those quoted above except that item 3 (c) does not permit an opinion to be given as to the severity of head injuries even when the condition is definitely determined.



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About People

Administrators

Dr. Lloyd H. Gaston became director of St. Luke's Hospital, New York City, on January 1, succeeding **Dr. Claude W. Munger,** who retired last July because of ill health. Doctor Gaston received his medical degree from the Medical College of Virginia in 1930 and the degree of doctor of public health from Yale University in 1941. He joined the staff at St. Luke's as assistant director in 1945 and had been acting director since Dr. Munger's retirement.

Thomas A. Higgins is now assistant administrator of University Hospital, Chicago, having assumed his duties there February 1.

James McKelvey Jr., former administrator of Grafton City Hospital, Grafton, W.Va., is now administrator of Chambersburg Hospital, Chambersburg, Pa. Mr. McKelvey received his master's degree in hospital administration from Northwestern University.

Carl Parrish, who has been affiliated with the Medical College of Virginia since 1935, has been promoted from administrator of St. Philip and Dooley hospitals to assistant director of the Hospital Division of the College, succeeding **Dr. Margaret DuBois.** He has been replaced as administrator of St. Philip and Dooley hospitals by **R. H. Crytzer,** formerly administrative assistant of the outpatient department.

John L. Howell, assistant administrator of Pennsylvania Hospital, Philadelphia, since 1942, has resigned to become acting administrator and chairman of a three-month study at South Highland Infirmary, Birmingham, Ala. His study will cover the present position and probable future of the infirmary and will be used by the hospital's board to determine capital needs in view of the over-all Birmingham hospital situation.

Louise F. Lenhardt has been appointed administrator of Warren A. Candler Hospital, Savannah, Ga., where she has been serving as acting administrator for the last two years.

Jacob Goodfriend has been appointed administrator of Barnert Memorial Hospital, Paterson, N.J., succeeding the late **Louis Roth.** Mr. Goodfriend was formerly executive director of the Beth Moses Division of Maimonides Hospital, Brooklyn, N.Y.

Dr. G. A. W. Currie is the administrator of the University of Colorado Hospitals, Denver, succeeding **Robert Kniffen.** Dr. Currie attended the course in hospital administration at Columbia University and served at St. Luke's Hospital, New York City, with Dr. Claude W. Munger.

Arthur R. Zeiter has been appointed administrator of the Douglas County Jarman Memorial Hospital, Tuscola, Ill.

John H. Prescott, assistant superintendent of Sutter General and Sutter Maternity hospitals, Sacramento, Calif., has accepted the position of superintendent of Modoc Community Hospital, Alturas, Calif.

Dr. Mark A. Freedman has been appointed associate director of Montefiore Hospital, New York City. Dr. Freedman was assistant director of Bronx Hospital, New York City, for the last three years. Prior to that he served as an executive officer of the Fifth General Hospital overseas, with the rank of colonel.

Dr. L. C. French, formerly administrator of Knickerbocker Hospital, New York City, has been named administrator of Mesa Hospital, Mesa, Ariz.

Raymond W. Brooke has been appointed administrative assistant of the Johns Hopkins Hospital, Baltimore. Mr. Brooke was administrator of Memorial Hospital, Easton, Md., from 1942 to 1945.

Harold C. Mickey, superintendent of Duke University, Durham, N.C., and director of Duke University School of Hospital Administration, has been appointed eastern manager of James A. Hamilton and Associates, hospital consultants, of Minneapolis. A 1931 graduate in business administration from the University of Colorado, Mr. Mickey began his business career in Colorado. He went to Durham to become assistant superintendent of Duke Hospital in 1936, and in 1944 he was made superintendent and director of the school of hospital administration.

Robert T. Besserer, formerly of the Fort Pierce Memorial Hospital, is the new administrator of Winter Haven Hospital, Winter Haven, Fla. He has been succeeded at Fort Pierce by **Edwin Radinsky.**

Sister Mary de Sales, formerly of St. Mary's Hospital, Clarksburg, W.Va., has been transferred to Dodgeville, Wis., where she is now superintendent of St. Joseph's Hospital.

Department Heads

Mrs. Mary K. Bloetjes, who was in charge of the dietetic department of the Hospital for Joint Diseases, New York City, for twenty years, has been appointed nutrition executive at Montefiore Hospital, New York. She succeeds **Lenna F. Cooper,** who retired last summer to enter consulting practice.

Theodora R. Lynch has accepted the appointment of director of nursing at Lawrence Hospital, Bronxville, N.Y. Miss Lynch, formerly director of nursing at Sydenham Hospital, succeeds **Antonie M. Reuter,** who died in November after serving for twelve years.

Hannah O. Hotvedt, for twelve years chief dietitian at the Corwin Hospital and Clinic, Pueblo, Colo., has been named head dietitian for the General Rose Memorial Hospital, soon to open in Denver. Miss Hotvedt went to Hawaii in 1938 to organize and operate the dietetics department at the G. N. Wilcox Memorial Hospital in Lihue, Kauai, but returned to Corwin Hospital in 1944. **Marjorie Pickett,** formerly chief pharmacist at Mercy Hospital, Denver, and at the Naval Hospital at Mare Island, Calif., has been appointed head pharmacist at General Rose.

Mrs. Grace Lyman Price, R.N., is the new director of nursing at Herrick Memorial Hospital, Berkeley, Calif., suc-

(*Continued on Page* 170.)

Conducted by Raymond P. Sloan

CIVIC ADVISORY BOARD

serves as a two-way channel between the hospital and its community

SISTER MARY BENIGNUS
Administrator
Our Lady of Mercy Hospital
Mariemont, Cincinnati

OF ALL modern enterprises none is more complex than the hospital. This statement applies to all hospitals regardless of size or the degree to which their work may be limited. The more complex a field of endeavor becomes, the more necessary is it that a well defined organization be worked out and made effective. By this means is produced a coordination of individuals and groups cooperating in such a manner as to prevent neglect of any duty or duplication of effort, and producing the desired result.

DEFINE TERMS CLEARLY

There is the possible danger of utter confusion or incorrect interpretation of the function of any organization or adjunct section of that body unless one is clear in defining the terms that are used. This can be particularly true in discussing the various types of hospitals and their respective administration.

At the head of the hospital organization is the governing board. Under different conditions this group may be called the board of directors, the board of trustees, or by other appropriate designation, depending upon ownership and control of the hospital, but, regardless of the name by which it is called, the governing body has the same responsibility and authority.

A federal governmental hospital is controlled by some department of the federal government. Top authority in nongovernmental hospitals is in the hands of boards of trustees. Corresponding authority in a Catholic hospital is directly under the organization of a particular Religious Order.

This paper is concerned with a discussion of the creation and function of a civic advisory board and the status of this board as an adjunct organization in a Catholic hospital. There seems no reason to believe that similar civic advisory groups could not perform in much the same way in all non-Catholic voluntary hospitals.

The objectives of a civic advisory board as such have never been formulated for publication. This type of organization is comparatively young but it has definite advantages to offer to Catholic hospitals. The volunteer hospital will benefit by taking the public into its confidence if it is to keep its place secure in this changing world. Upon the esteem in which a community holds a hospital will depend in the present the success of its plans for improvement and expansion, and in the not too remote future, perhaps its very existence.

By unquestionable right, any hospital that is blessed with good internal relations should be rewarded with good external relations. This statement may lead one to conclude that the purpose and aim of the civic advisory board coincide with those of the hospital's public relations program. But the board under discussion is primarily an "advisory" one.

Generally speaking, this board consists of a well chosen group of outstanding citizens who represent the various industrial and social interests of the community. By reason of their experience in diversified fields, they are qualified to offer expert ideas and plans to assist the hospital in serving the needs of a certain locality. These individuals are people who in their daily contacts have a consistent and exact knowledge of the public pulse. They serve as a channel by means of which the hospital is made aware of community needs, thus making it possible for the hospital to extend its sphere of usefulness. This board may likewise serve as a medium of public education by promoting a greater realization of the benefits of the hospital to the community. If such a group is vitally conscious of the needs of your hospital, be assured that it will lose no opportunity to advance its cause in a variety of ways.

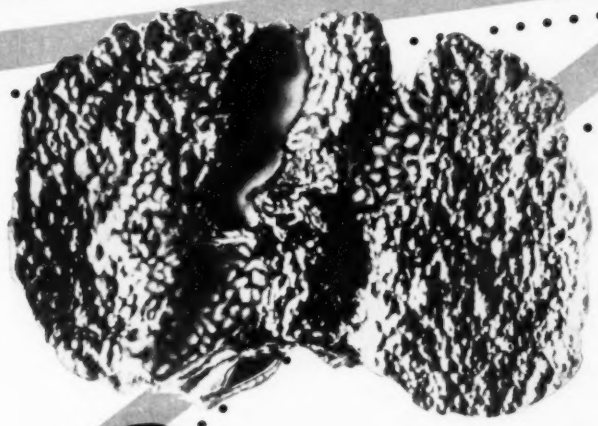
CANNOT HOLD ALOOF

More and more we realize that our hospitals cannot stand alone amid the social complexities of the communities which surround them. We must get rid of aloofness and educate the general public as to the character and usefulness of our institutions. Here, as in everything else that pertains to hospitals, we are for the most part intimately associated with the people whom our hospitals serve. It is from the local ranks that the members of the civic advisory board must be taken.

Obviously then, the character of those who are to be the actual members is determined by the type of patients the hospital serves. Furthermore, as already indicated, these leaders should be enlisted from various

Condensed from a paper presented at the Sisters of Mercy Hospital meeting, Chicago 1948.

To forestall this eventuality



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fields of endeavor. We must remember that present-day hospital activity is "Big Business," the varied commissary departments of which rival those of any particular industry or business. In fact, any single department, apart from caring for the sick, may be comparable to a full-time business; for examples of such departmental activity you may consider the relative needs of the power house, laundry, cafeteria and business offices.

Numerous men and women in each community are anxious to volunteer their services to stimulate and assist any particular section of the hospital which serves them. However, in order to encourage them in their efforts and to sustain their good will, it is fundamental that in some way these good people be made familiar with the problems and difficulties which the hospital daily encounters. We can't expect people to understand and remedy our needs if knowledge of these needs is lacking.

INDUSTRIAL LEADERS NEEDED

It is most desirable that the civic advisory board include some well chosen industrial leaders. Such individuals are most conscious of the relations existing between expenses and income. This does not imply that board members should, at any time, know the complete financial standing or other inner workings of the hospital or of the religious community.

New industrialists coming to your city should be personally invited to the hospital. Neither is it necessary that the president of every important organization be on your board. Frequently you will find outstanding talent farther down the line. For example, a good personnel manager in a city concern may give valuable information and aid; the same may be said of a good purchasing supervisor or agent. The presence of a representative from a recognized insurance agency may be of benefit. It is also well to have lawyers and bankers represented. These gentlemen are often instrumental in influencing people to make bequests in favor of the hospital.

Depending upon local circumstances, there may be other business or social groups which should be represented. It is customary but not necessary that at least one priest be a member of the board and, dependent upon local situation, it may be wise to include clerics from non-Catholic sects. The big thing is to have the group consist of people who are *active* and *interested*. Avoid introducing individuals who will seek favors for themselves or for their friends. Keep in mind that the personnel of this board will strongly influence the relations between your hospital and the public.

In this respect the group will not be as active as a public relations committee, but it can be made to function as an excellent unit-medium to further the particular and general interests of the hospital. The public will receive a positive, sympathetic hospital education from those among its members who are best qualified to know the hospital. To such a group people will listen and respond.

At this point it is pertinent to note that prominent among the media which the Catholic hospital can employ for healthy publicity is the local newspaper. To achieve this, emphasis should be placed on the cultivation of a friendly, sympathetic understanding with the editor. You may even wish to consider him as a possible board member.

Perhaps it is wiser to have this particular service group designated as the civic advisory board rather than the "lay" advisory board. It is healthy repetition to insist once more that the object of this board will be to advise the management and to assist as far as possible with any work that is for the welfare of the hospital. As already indicated, the board will consist of representative people of varied interests in the community. The president, vice president, secretary and treasurer of the hospital corporation may serve as members on this board.

The actual number of board members should be determined and governed by code regulations. For all practical purposes a maximum number might be forty or possibly fifty. It is somewhat difficult to work with large numbers and where you have quantity you may be deficient in quality. However, in this connection, it would be possible to consider and use your officers as an effective quality group without sacrificing a large representation.

The officers of the civic advisory board should be as follows: chairman, vice chairman, secretary and recording secretary. A constitution should be formulated. This constitution may be revised or amended at any regular meeting of the board provided there is a two-thirds affirmative vote of the members present. At least a twenty-day notice of the proposed amendment should be announced in writing to each member.

The code of regulations specifies the place and time of meetings, in what a quorum shall consist, and the duties of the various officers. The order of business follows the routine of the regular parliamentary law procedure. At the annual meeting there shall be elected a chairman, vice chairman, secretary, recording secretary and nominating committee consisting of three members. All officers and the nominating committee for the ensuing year shall be nominated by the acting committee and be elected by ballot.

PROVIDE FOR EMERGENCIES

Some time previous, perhaps a few weeks before the date of election, the nominating committee shall mail to each board member a ballot upon which shall appear two names for each office, or if only one candidate is selected for any office, that candidate's name shall be designated. Provisions are made for the filling of vacancies, the dropping of disqualified members and any other emergency that may arise within the organization which might prevent a capacity function.

Special committees are considered necessary. You may designate these committees as you wish. The following suggestions may prove helpful:

1. Building and grounds
2. City relations
3. County and townships
4. Industrial relations
5. Finance
6. Legal
7. Nursing school
8. Publicity committee
9. Service league

Limit these committee groups to approximately five members. The chairman will appoint the members of these standing committees. To him all committee reports should be submitted either orally or in writing, or both.

The supervisor or administrator should check and know personally each person who is being considered for membership on the civic advisory board. The administrator should also know those who are being nominated to the various offices. The members of this board must always understand

(*Continued on Page* 132.)

Hospital Viewpoint Influenced by New Facts on Costs of Electric Cooking!

ANOTHER STORY OF EXTRAORDINARY SAVINGS WITH *HOTPOINT ELECTRIC COOKING*—

from the Methodist-Episcopal Hospital, Indianapolis with 1,045 on the payroll, 645 beds, and 85 bassinets.

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152 Watts, Per Meal, Per Person

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Problems in extending HOSPITAL PRIVILEGES to new physicians in the community

LUCIUS W. JOHNSON, M.D.
San Diego, Calif.

ONE of the greatest migrations the world has known occurred in this country during and after our latest war. It was marked by a proportional shifting of doctors, largely toward the West. In several cities the number of physicians was more than doubled, and this has created many problems for hospital staffs.

The administrator of a large city hospital complained, "In my institution we have as many doctors on the staff as we have beds." This remark was greeted with a disparaging snort by another who said, "You don't know anything about trouble. In my hospital we have twice as many on the staff as we have beds." When such conditions exist one can be sure that some of the staff are not getting many patients into the hospital, which must lead to bitterness and charges of discrimination.

SOME ILL FEELING EXISTS

Physicians returning from duty with the armed forces frequently found that newcomers had displaced them, not only with their former patients but also in their staff positions. Time has largely settled that problem, but a considerable amount of ill feeling still exists. In service hospitals I meet many doctors who, after battling with overcrowded professional conditions in their former home towns or cities, have signed up again, this time for keeps, with some government service.

It is generally recognized as a bad thing for the community when a well qualified physician moves in but cannot find a bed in a good hospital for his patients. His only recourse often is to gravitate to a hospital of a lower grade. If he is an older man with good background and firm character he is likely to use his influence to raise the standards of the hospital in which he works, but the younger ones seem to lower the quality of their practice to the average of the group in which they find themselves.

Some form of probationary period for those being admitted to the staff has great value and is almost universally required by good hospitals. The usual custom is to admit new members to the associate staff and then to grant wider privileges when the supervisory committee recommends it. Advancement to the active staff may come almost at once to those of proved standing and ability, while for others it may be indefinitely delayed. In surgery, most hospitals grant only minor privileges to new members whose surgical ability has not been clearly demonstrated. That is, the physician may treat any patient whose life is not endangered, or when there is no hazard of serious disability. For the graver cases he must call in a senior surgeon. When the supervisory committee recommends it to the staff, he may be granted intermediate privileges, which means that he may care for any patient, without supervision, whose life is not in danger. Major privileges may be granted whenever the new member is considered by the staff to be qualified.

During the probationary period the work of the new member is carefully observed. His patients for major surgery are studied also by a senior surgeon, and he must have a senior work with him while operating. He is expected to prove his fitness and loyalty by strict obedience to the rules relating to records, taking part in staff meetings, and giving time for instruction of nurses, interns and residents. His attitude toward all employes is noted. Records are kept of his death rate, infection rate, necropsy rate, and consultation rate. The percentage of correct preoperative diagnoses, the quality of his surgical judgment, his technic, his preoperative and postoperative care are observed. The radiologist, the pathologist and the tissue committee pay particular attention to his patients, the examinations he requests, and the interest he shows in the results.

AUDIT OF SURGICAL ABILITY

The professional audit is coming more and more into favor as a method of appraising the surgical ability and judgment of each staff member. If it is properly done, by an experienced and disinterested person, it points out clearly those surgeons who are well qualified and those whose privileges should be restricted. In one hospital I was told that a small minority of the staff bitterly opposed having the audit. When the results were submitted, the ones who opposed it were shown to be the ones who were enjoying privileges beyond their ability.

In Cleveland, the hospital council has set requirements for those desiring to do major surgery in member hospitals. They must have one of the following: (a) two full years of hospital training, at least one of which shall have been in general surgery in a hospital approved for graduate training of surgical residents; (b) membership on the active surgical staff of a member hospital and classified to do general surgery; (c) fellowship in the American College of Surgeons.

The recommendation of the American College of Surgeons is that major

Presented at the Hospital Standardization Conference, American College of Surgeons Clinical Congress, Los Angeles, 1948.

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WHEN IS IT INDICATED?

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WHAT IS THE DOSAGE?

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50 cc. vials containing the equivalent of 5 Gm. streptomycin base

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surgical privileges be granted only to those having the following qualifications:

1. Graduate of an approved medical school.
2. At least one year of internship in an approved hospital.
3. Two years or more as surgical resident or as an assistant to a senior surgeon.
4. At least six months of acceptable postgraduate work during this period of five years.
5. Assurance that he has done at least fifty major operations himself and has assisted at fifty others, all of which have been fully recorded and show acceptable end results.

The San Pedro Community Hospital, San Pedro, Calif., has adopted rules from which I quote:

"That any surgeon who belongs to the American College of Surgeons, or who is certified by the American Board of Surgery, be accepted with the rank of senior surgeon, provided there is no moral or other reason to make him unacceptable.

"That the men who have been doing major surgery acceptably for four years or more in this hospital likewise be given the rank of senior surgeon.

"That new members who wish to do major surgery be required to submit evidence that they have had three hospital years, two of which have been devoted to surgery. Their work is to be observed by the surgical committee before they are granted the privilege of doing any independent major surgery.

"That those who have had no surgical residencies may apply for the position of junior surgeon after they have had four years of general practice."

SMALL HOSPITALS EXERT CONTROL

Do not get the idea that firm control of surgery is a matter only for the large hospital. It is being carried out with great success by many hospitals of fifty beds or less. The Flagstaff Hospital in Arizona is a conspicuous example. In addition to the standard requirements, each surgeon must record a diagnosis, in terms of the Standard Nomenclature, for his patient when scheduling the operation. Speculative diagnoses, such as "pelvic lap." or "abdominal section," which suggest that the surgeon hasn't bothered to examine the patient thoroughly but hopes to find a diagnosis during the operation, are not acceptable. The diagnosis is later checked against the clinical and pathological records. Any surgeon with less than 75 per cent of correct diagnoses is asked to take his patients elsewhere. Errors in diagnosis are discussed with frankness in the monthly staff meetings.

These examples and quotations give an idea of the manner in which the standards of surgery are being upheld in good hospitals. In contrast to these, I see a number of institutions in which many appendectomies, also operations on female pelvic organs, are done without anything in the records to show that a physical examination was made or that a preoperative diagnosis was recorded. No progress notes are written to show the effects of the operation, and the tissues are not sent for pathological examination. There is nothing to indicate that any operation was justified or whether the patient was better off after the surgery. On the editorial page of the *Los Angeles Times* for Aug. 16, 1948, was a biting comment on such hospitals, written by a layman.

The rumor has been widely circulated that the American College of Surgeons is opposed to allowing surgery to be done by general practitioners, which is untrue. The attitude of the college is that privileges in the hospital should be granted to each physician commensurate with his training, ability and ethical conduct. The extent of the privileges should be decided by a qualified committee of the staff, in a manner clearly stated in the by-laws of the hospital.

Like any exercise of authority, care in selecting new staff members may cause hard feelings. In several places I have been told that physicians were threatening to sue hospitals which, they said, were depriving them of their right to earn a living by not admitting them to practice in hospitals. In no case that I know of was a suit actually started. The attorneys for the hospitals told them that they were well buttressed by the great number of court decisions which stated that it is the duty of the governing board to select members of the staff with regard not only to their medical skill but also to their adaptability to the rules and discipline of the institution.

A state license gives the doctor the right to perform any operation, whether it is needed or not and without regard to his judgment or technical ability. Therefore, it becomes necessary for the hospital to establish safeguards for the patient, to protect him from the dangers of unnecessary surgery and incompetent surgeons. Before a hospital can become approved by the American College of Surgeons it must be made evident that such safeguards have been set up and that they are enforced.

Staff problems of hospitals have not been reduced by the current agitation for increased privileges for general practitioners. The fact is that new and embarrassing ones have been developed. The well known tendency in human affairs for the pendulum to swing too far in each direction before settling down is being demonstrated. Without doubt, the complaint of the general practitioners that their privileges in many hospitals were being more and more restricted had much merit. Now that those practitioners are organized and feel their strength, they show a tendency, in some institutions, to abrogate all control of surgery and to take the attitude that no person has authority to tell the general practitioner what he can or cannot do. Here are some of the unfortunate results that I have observed, resulting from friction between general practitioners and the rest of the staff.

"BATTLE TO THE DEATH"

In Hospital A the specialists complain that the general practitioners have voted themselves into all the staff offices and refuse to allow the others to express any opinion on the conduct of hospital affairs. The chief of staff states his position clearly: that it is a battle to the death between his group and the rest of the profession, and he is on the side of the general practitioner.

In Hospital B the members of the general practitioner group have notified the rest of the staff that the rules and requirements for the control of surgery do not apply to them. They say that nobody is to be allowed to tell any one of them what he may or may not do.

In Hospital C the surgical committee recommended limitation of the privileges of one of the general practitioners because his frequently poor surgical results were believed to endanger the public relations of the hospital. The only action taken was to dismiss the surgical committee, among which were fellows of the American College of Surgeons and diplomates of the American Board of Surgery. General practitioners were appointed to replace them.

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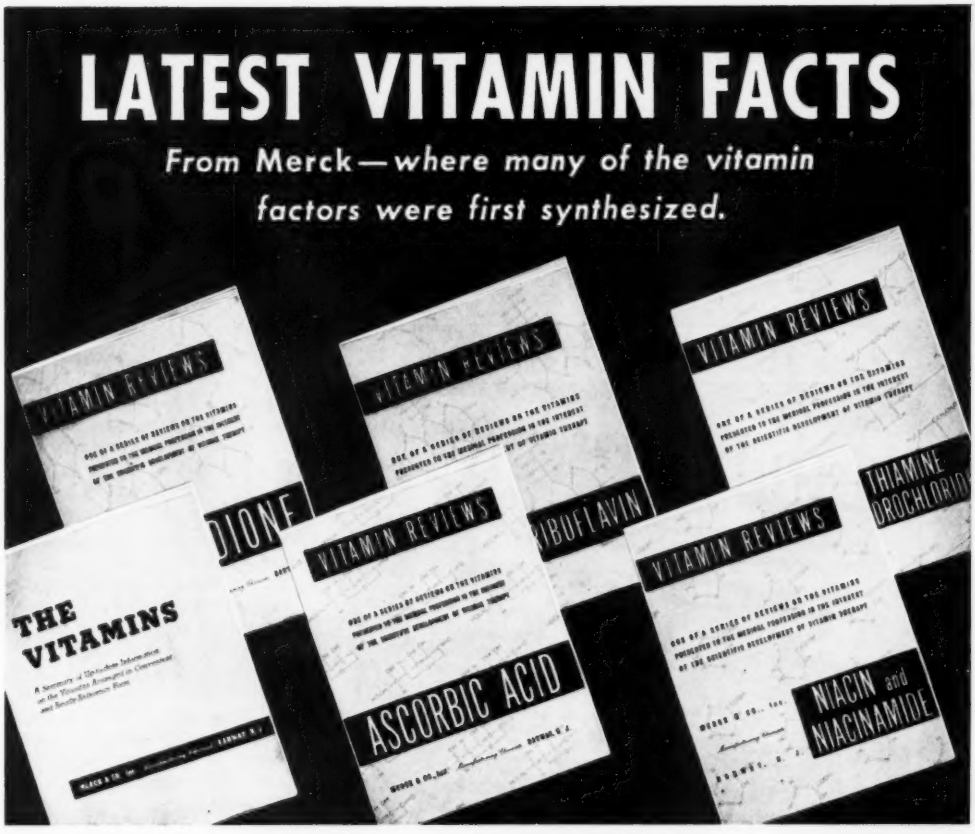

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MERCK VITAMINS

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That is a very human way to act, and we all appreciate the pleasure that the general practitioners feel in their newly gained strength. However, there are more important things to be considered than the momentary advantage of any group. The control of surgery in approved hospitals has been built up by the combined efforts of medical staffs, administrators and trustees through several generations. Its one purpose is the protection of the patient from unnecessary surgery and incompetent operators. The general public is becoming educated in the need for this protection and is learning what it means to have a hospital approved by the American College of Surgeons. That recognition is gravely jeopardized by any relaxation of the control of surgery.

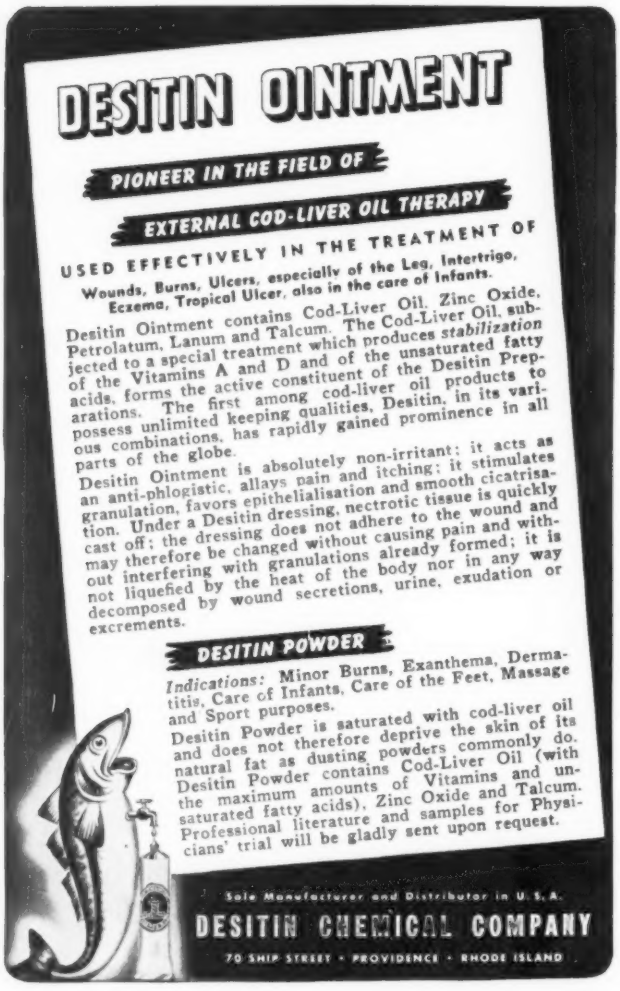
A hospital cannot continue to maintain high standards if the medical staff is divided into two opposing groups, one with its members limiting themselves to clearly defined specialties, while members of the other are doing everything in every field. Until some national body defines the limits of the scope of the general practitioner, it will have to be done in each individual hospital. The only safe basis is to grant privileges to each member, commensurate with his training, ability and ethical conduct, as determined by a qualified committee of the staff.

Sometime ago I listened to a talk by a physician who had been sent by our government to appraise governmental control of hospitals and medical practice in England and on the Continent. The picture he painted was not a pleasant one, and he ended with this message from a group of leading practitioners in England, "If you want to keep out of the mess we're in, start now to clean your house." This was amplified by listing the current practices which breed public ill will toward physicians and hospitals. Among them were excessive charges, division of fees, unnecessary and incompetent surgery, and failure to provide night service.

We all have noted the articles in the lay press concerning unnecessary operations and incompetent surgeons. They were reprinted in several magazines and aroused widespread discussion. At the same time there is a well organized and skillfully conducted agitation for government control of medicine and its practitioners, also the hospitals in which they work. This is a time for the medical and hospital professions to examine their defenses against such attacks and to strengthen the weak points. It is definitely not a time to break down the safeguards which have been erected to protect the patient.

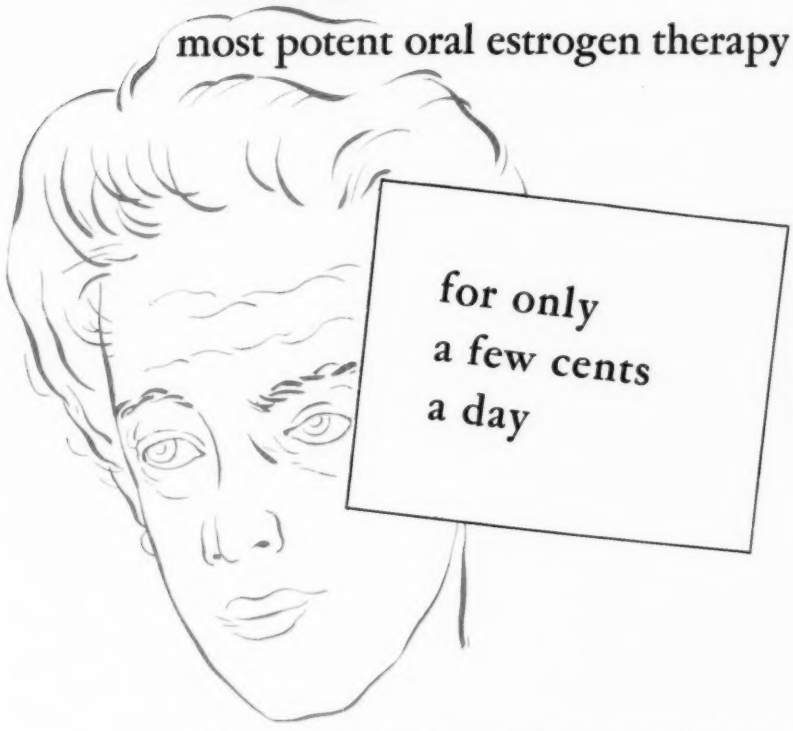
Efforts to divide hospitals and doctors into warring groups are a part of the strategy of our common enemies. If voluntary hospitals and independent practice of medicine are to continue, then the trustees, the medical staffs, and the administrators must combine to accomplish these things:

1. Emphasize constantly the basic fact that every act and decision in the hospital must be in harmony with the purpose of providing the best care of the patient.
2. Enforce the rules and by-laws which protect the patient from unnecessary surgery and from incompetent operators.
3. Settle all disputes on a fair basis within the hospital group.
4. Bear in mind that every split-up of the medical staff into opposing factions, every rift among staff, trustees and administration is detrimental to the patient and encouraging to our common enemies.



ETICYLOL

most potent oral estrogen therapy



A single 0.02 mg. tablet of Eticylol* (ethinyl estradiol) costs only a few cents. This small dose, administered daily, is sufficient to maintain the average menopausal patient.

Eticylol is not only convenient but is pleasant to take – with no disagreeable odor or after-taste. The "sense of well-being," associated with the use of naturally occurring estrogens, is usually experienced. Daily administration of this steroid sex hormone maintains a relatively stable level of estrogen in the body. When therapeutic doses are used, side effects rarely occur

ETICYLOL: Tablets of 0.02 mg. (white), and 0.05 mg (yellow) – bottles of 100 and 250

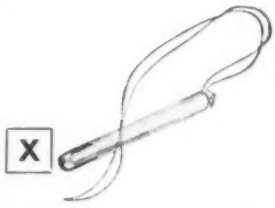
*Formerly Ethinyl Estradiol-Ciba

Ciba PHARMACEUTICAL PRODUCTS, INC., SUMMIT, NEW JERSEY

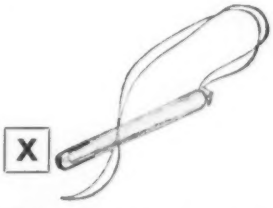
ETICYLOL (brand of ethinyl estradiol)—Trade Mark Reg. U. S. Pat. Off. 2/1422M

BETTER THAN CULTURES

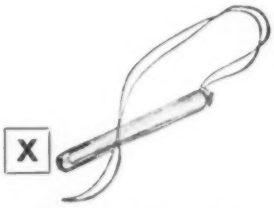
—*Diack Controls* provide a better check on sterility of your autoclaved goods than *cultures*.



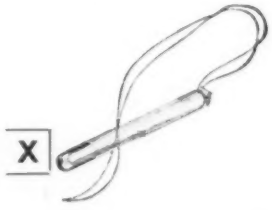
Safer—B. subtilis is destroyed far below melting conditions required for Diacks.



Time saving—a wait of one to ten days incubation with cultures. No wait with Diacks.



Economical—cultures are costly in time consumed alone. Diack's cost is comparatively lower.



Checks Autoclave before next load —you may under-sterilize several loads before previous culture indicates a faulty autoclave. An unmelted Diack will check it before the next load.

Diack Controls

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Notes and Abstracts

Prepared by the Committee on Pharmacy and Therapeutics
University of Illinois College of Medicine, Chicago 12

PRESENT STATUS OF

Medical Research and Teaching in Germany

A BRIEF trip to Germany to the first international scientific meeting held in Hamburg from Sept. 24 to 26, 1948, afforded an opportunity to obtain some information on the state of medical teaching and research in Germany.

This meeting, devoted to advances in therapy in dermatology and syphilology, was attended by more than 500 physicians. About 10 per cent of the participants came from foreign countries, Scandinavia, Switzerland, France, Austria, Holland, England, and the United States. German dermatologists represented all parts of Germany, including the Russian Zone.

MEDICAL TEACHING

In spite of war damages to buildings and facilities and a depletion of the teaching staff, the medical schools in Western Germany have a higher enrollment than ever before. For the first time in the history of Germany the admission to medical schools has been restricted. Veterans of the war and those whose medical training was interrupted enjoy a certain priority in being admitted. About 20 per cent of the medical students are women.

Today's students appear to be eager, serious minded and enthusiastic. Many of them apparently hope to replace the spiritual vacuum left by the explosion of the Hitler myth with sound and systematic scientific knowledge. Most of the teaching, even in the clinical subjects, still consists in formal lectures delivered to large classes of from 200 to 500 students. Instruction of smaller groups in a more informal manner is still an exception to the rule.

The lack of good textbooks is a universal complaint. There are being printed some new editions of the more important textbooks, as for instance in pharmacology and therapeutics. It is admitted that the publishing houses, of which the majority are located or relocated in the western zones of Germany, are making a valiant effort to produce more textbooks and publish more periodicals. However, new editions of textbooks as well as routine editions of medical journals are drastically restricted by the paper shortage. Furthermore, the price of new books is too high for many students. Thus, older editions obtained second hand are still being used by too many students. Another complaint made by faculty members and students alike is the dearth of good teachers.

MEDICAL RESEARCH

Medical research in Germany presents a shocking example of the havoc caused by political restrictions, racial discrimination and an enforced isolation from the science of the rest of the world. There exist now vast and important fields in medical research, and particularly in therapeutics, which have been opened and developed without a single contribution from German laboratories. Reference is made to antibiotics, antihistamines, fundamental studies in metabolism using radioactive isotopes, treatment of shock with human plasma, and to many others.

SULFONAMIDES

The history of sulfonamides presents a particularly emphatic example of the rapidity of the downfall of therapeutic research in Germany. Two years after its brilliant discovery and pioneer work in this field, German re-

The New Colson Folding Wheel Chair

More Comfort for Those Who Need It Most

Light in weight, easy to handle or store, attractive and comfortable — that's the new Model 4318 Colson wheelchair.

Seats and back are dark blue plastic leather — padded with foam rubber for greater comfort. The light weight tubular steel frame is strong and rigid. Foot boards fold for ease in entering and leaving chair. Large wheels are heavy-duty tangent spoke type, full ball-bearing with cushion rubber tires and hand rims for easy operation. Casters have double ball-bearing swivels and steel disc wheels with cushion rubber tires.

These chairs can be supplied with polished chrome plated finish on all metal parts or gray baked-on enamel finish. Two styles are available — large wheels in front recommended for use indoors — large wheels in back for outdoor use. Colson chairs render years of comfortable trouble-free service.

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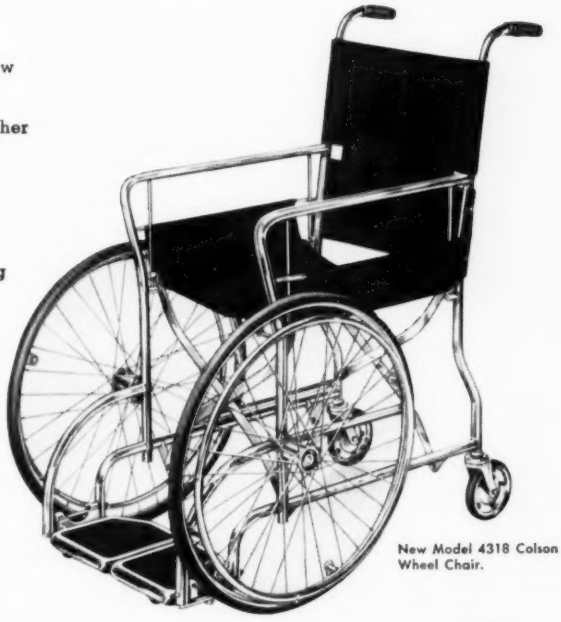
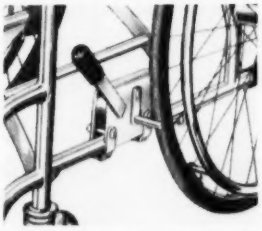


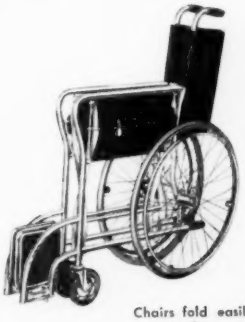
New Model 4318 Colson Wheel Chair.

Extra Accessories For Greater Comfort

Model 4327 arm rests are padded with foam rubber—match seat and back.



Model 4328 brake is easily operated by occupant — locks chair securely.



Chairs fold easily and compactly — require minimum storage space.

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WHEEL CHAIRS • • WHEEL STRETCHERS • • INHALATORS • • INSTRUMENT TABLES

search was outdistanced by France, England and the United States. The mode and mechanism of action of sulfonamides were intensely studied in these countries. Newer, safer and more effective derivatives were rapidly developed outside of Germany.

The Germans, meanwhile, continued to use preparations like the ill-fated disulfonamides, Uliron, and Neo-Uliron. These preparations, never admitted to the United States, have been used in Germany for years in the face of the serious toxic effects encountered. Only recently, they have been withdrawn from the market. Sulfapyridine, regarded in this country as obsolete and displaced by less toxic compounds, still continues to be used widely in Germany.

Sulfathiazole, made by various manufacturers in Germany, appears to be the most popular sulfonamide. Sulfadiazine and sulfapyridine are manufactured under foreign license. It is probably no overstatement to say that present German knowledge of sulfonamides and their therapeutic use is second hand, based on the advances that have been made particularly in this country during the last ten years.

AVAILABILITY OF PENICILLIN

Penicillin is available in Germany for the treatment of gonorrhea and for the treatment of gram-positive bacterial infections which do not respond to other therapy. It is available only for injection but not for topical use. A few selected cases of syphilis are now being treated with penicillin.

In view of the fact that both Denmark and Sweden manufacture their own penicillin, it is difficult to understand why the German industry has not as yet made a greater effort in producing penicillin. Some penicillin is being made by a small manufacturer (Penicillin, Inc.) at Goettingen in the British Zone. However, the supply is insufficient and the quality of penicillin does not compare with preparations made in the United States.

ANTIHISTAMINES

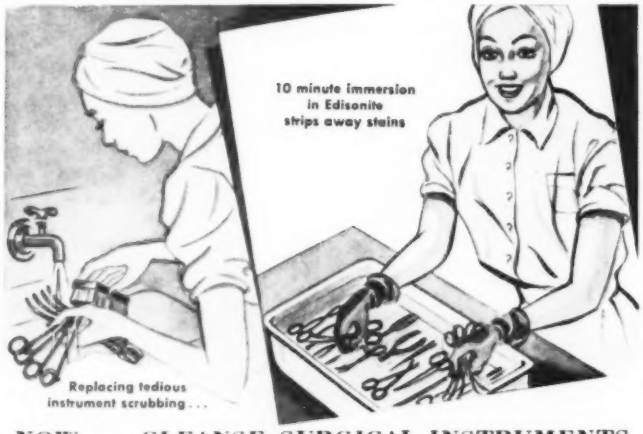
Except for a few meager review articles in their literature, the German physicians are quite unfamiliar with the treatment of allergic manifestations with antihistamines. A discussion of this topic at the meeting in Hamburg was carried almost exclusively by Swiss and other foreign participants. The rapid development of a host of useful antihistamine preparations came as a surprise to the Germans. At present, only one antihistamine compound (Antistine), manufactured in Switzerland, is available to them—and in totally insufficient amounts.

BLOOD SUBSTITUTES

Human plasma was never manufactured in Germany. Instead, the Germans developed during the war a blood substitute, Periston. It is still manufactured in large quantities. Periston is a colloid polyvinyl pyrrolidone of molecular weight of 25,000. It is given as a 15 per cent solution intravenously in relatively small quantities of from 250 to 500 cc. It is reputed to stay in the vascular bed for about forty-eight hours. Experimental data on its metabolism and excretion are still scanty. Its merits are extolled by comparison with saline infusions. The more critical comparison with human plasma is not made, obviously for the reason that plasma is not available.

LACK OF FOREIGN LITERATURE

Many German research workers are apparently still unaware of how far



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WITHOUT SCRUBBING

MANY NURSE-HOURS per week are being saved in hospitals where time-consuming instrument scrubbing has been replaced by *the new method* with Edisonite Surgical Cleanser. However many or long-dried the instruments, whether metal, glass or rubber, all come spotlessly clean and film-free after a 10- to 20-minute immersion in Edisonite's probing "chemical fingers."

THE EDISONITE FORMULA cleanses swiftly, thoroughly, *without mechanical effort,* by the detergent action of two modern chemicals—Sodium Hexa Meta Phosphate* and Sodium Lauryl Sulphate. Sodium Hexa Meta Phosphate combines with proteins to form a non-ionized soluble compound, thus hastening the disposal of blood and tissue. Sodium Lauryl Sulphate causes lowering of tension at the surface of foreign materials, rapidly dispersing blood, oil, fats and tissues into the solution. Instruments are ready for the sterilizer immediately after rinsing—without inspection.

HARMLESS to instruments and to hands. Aids in maintaining bright metal finish. Protects hands from soap dermatitis.

*Sodium Hexa Meta Phosphate—U. S. Pat. Reg. 19719.

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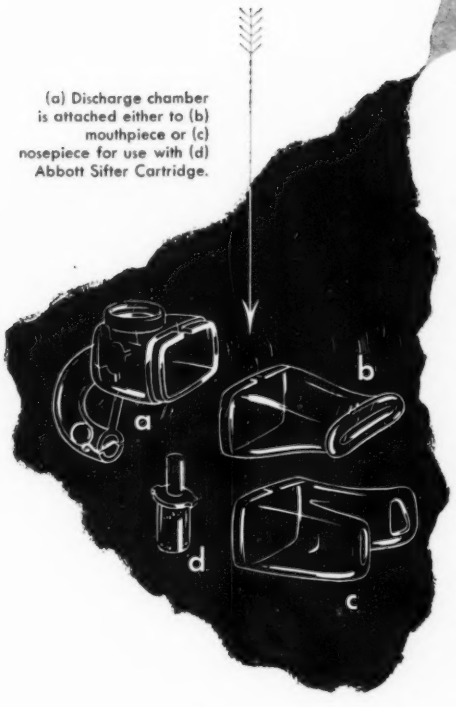
NEW

...a simplified device for Penicillin Powder Inhalation

(a) Discharge chamber is attached either to (b) mouthpiece or (c) nosepiece for use with (d) Abbott Sifter Cartridge.



HERE is an inexpensive little device for penicillin inhalation therapy that requires no supplementary equipment. It is the Aerohalor—a small plastic inhaler with attachments for oral or nasal inhalation. It is used with disposable Abbott Sifter Cartridges containing 100,000 units of finely powdered crystalline penicillin G sodium.

For oral inhalation, the patient simply attaches the mouthpiece, inserts a cartridge of penicillin powder and "smokes" it like a pipe—by inhaling, removing, exhaling. Nasal inhalation is similar using the nosepiece. The patient's respiration is the only motive power necessary.

This form of treatment is indicated for infections of the upper or lower respiratory tract produced by organisms susceptible to penicillin. It is contraindicated only for infections not susceptible to penicillin and for patients allergic to the drug. In one study, only 3 to 6 percent reactions, none serious, were reported in over 500 cases.*

Ask your Abbott representative for a demonstration of the Aerohalor or write for comprehensive illustrated literature. ABBOTT LABORATORIES, North Chicago, Illinois.

*Krasno, L., Karp, M., and Rhoads, P. S. (1948), The Inhalation of Penicillin Dust, J. Amer. Med. Assn., 138:344, October 2.

Aerohalor® — **Abbott's powder inhaler**

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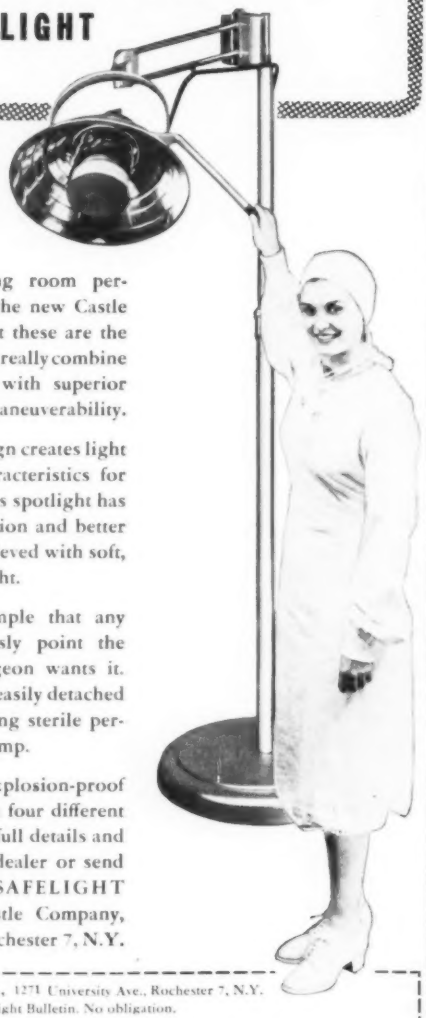
FINGER-TIP ADJUSTABILITY

QUALITY LIGHT



Surgeons and operating room personnel who have used the new Castle SAFELIGHTS agree that these are the first surgical spotlights to really combine explosion-proof safety with superior illumination and easy maneuverability.

The new reflector design creates light with better optical characteristics for surgery than any previous spotlight has offered. Deeper penetration and better shadow reduction is achieved with soft, cool, color-corrected light.

Adjustment is so simple that any nurse can instantaneously point the light wherever the surgeon wants it. Adjusting handle can be easily detached and autoclaved, permitting sterile personnel to position the lamp.

The SAFELIGHT explosion-proof lamphead is available on four different types of mountings. For full details and prices, see your Castle dealer or send attached coupon for SAFELIGHT Bulletin. Wilmot Castle Company, 1271 University Ave., Rochester 7, N.Y.

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Castle LIGHTS and STERILIZERS

medical science has progressed during the last ten years. This ignorance is fostered by the deplorable lack of foreign scientific literature. Not a single American scientific periodical has as yet reached the University Medical School in Hamburg. Distribution of foreign literature varies somewhat in the different zones of occupation. American literature is available at certain places in the American Zone (Heidelberg, Bremen), but medical schools in the British Zone have just obtained permission to subscribe to a few British journals only. The distribution of American scientific literature (much of it given at no cost to the Germans) could and should be vastly improved.

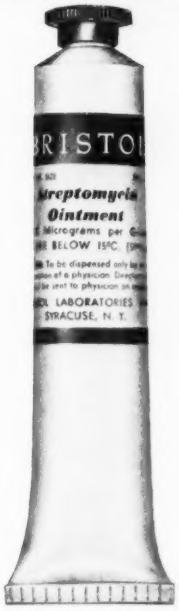
LACK OF DRUGS MANUFACTURED OUTSIDE OF GERMANY

Foreign drugs (with the exception of penicillin) are not available to the Germans, another factor contributing to the prolongation of their state of ignorance through isolation. There are more cases of arsenical intoxication than ever before, possibly due to nutritional conditions rather than to changes in such drugs as neoarsphenamine. Some physicians may have heard of the effects of B.A.L. (dimercaprol), but none has ever seen or used it.

Against the bleak background of devastation in the cities, incredible housing shortage, and lack of books and literature, it is astonishing to see what faith and confidence the Germans place in their efforts to reconstruct the country. Every little sign of improvement in living and working conditions is pointed out to a visitor. In the face of what remains to be done in reconstruction, their faith in their ability to accomplish this goal is rather moving.

Most hospitals have been repaired or rebuilt since all buildings serving educational purposes have priority in the program of reconstruction. The working conditions at the hospitals and in the laboratories which have escaped the bombing are almost normal. However, one of the most serious obstacles to recovery of medical research in Germany consists in the depletion of the ranks of competently trained scientific workers in the productive age groups. The price for the neglect of training and of research in the medical sciences during a period of almost fifteen years is very high. It can indeed not be paid in full for many years.—KLAUS UNNA, M.D.

Streptomycin *is now available in* Ointment *form*



Here is another original contribution to the antibiotic armamentarium from Bristol Laboratories: streptomycin sulfate for topical application, in a smooth, greaseless, ointment base. This significant development of Bristol research is noteworthy for the following:

1. A Broad Antibacterial Spectrum

The variety of bacteria destroyed or inhibited by streptomycin is remarkably broad. Its antibacterial spectrum surpasses those of other antibiotics in current use for topical application.

2. Less Sensitizing

Streptomycin in ointment form minimizes the greatest single objection to topical antibiotic therapy in that it is demonstrably less sensitizing.

3. A Water-Soluble Ointment Base

Bristol Streptomycin Ointment is unusually pleasant to use, because it is incorporated in a smooth, water-soluble base. Despite the fact that there is no grease or oil, adequate potency can be expected to persist throughout the full dating period of nine months after manufacture.

Bristol STREPTOMYCIN OINTMENT is indicated in skin and wound infections due to streptomycin-sensitive organisms. Each gram of the ointment contains 5000 micrograms of pure streptomycin.

Available NOW from your usual source of supply, in 1 oz. tubes, singly, or packed 12 to a carton.

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Conducted by Mary P. Huddleson

Small Things Make a BIG Difference

in the patients' reactions to the hospital's food service

J. A. BLAHA
Administrator
Lockport City Hospital
Lockport, N.Y.

THE nemesis of all hospital administrators is *food*, the silent octopus which takes 25 per cent of the hospital budget. Yet food can be the greatest possible asset we have toward better public relations. However, for the most part we continue to live with our food problem and let every Bridge Club, Mother's Club and Parent-Teacher Association in the community we serve rake us over the coals while we just shrug our shoulders and decide that here is a problem that cannot be overcome. Our hospital was no different in that respect from any other in the United States and Canada; nevertheless, we finally did something about it, and much to our surprise we saved money and improved our public relations beyond our fondest expectation.

After a careful study of our situation we decided to experiment with the following threefold program:

1. Selective menu for all patients.
2. Organized nourishment cart service twice daily.
3. Changing our dinner meal from noon to evening.

Any one of these factors could have bettered our situation, but a combination of all three made our experiment a success, and after several months' observance of the new program we are receiving continuous expressions of good will. We feel that food is no longer a problem in our hospital but a challenge to greater effort.

SELECTIVE MENU

It is a great pleasure to make rounds in Lockport City Hospital, Lockport, N.Y., between the hours of 9 and 9:30 a.m. as this is the time at which practically all patients, private room, semi-private and ward alike, make their selection of food for the following day. Ask our patients what they like about this system, and while you may get a multitude of answers, the majority will state emphatically that being allowed to select the food they like is highly important to their contentment and speedy recovery. One of the most interesting features of our menu for the patient is the "Quotation" or "Famous Saying" that is printed on it. It is not uncommon to have the patient save his menu for his friends and relatives.

In our studies of the selective menu we find it surprising that patients consistently, but apparently without cognizance of the fact, select the cheaper items. For instance, the cheaper cuts of meat are selected by a ratio of better than 2 to 1, while ice cream, gelatine and custards are selected by more than 3 to 1 over the higher priced desserts. Equally surprising is the fact that the patient is far happier with smaller servings of each item for the reason that he has selected it, and he is much more likely to eat the entire portion, thus reducing food waste.

The greatest benefit derived from the selective menu is that the patient, who is our only concern, is "telling us" what he wants to eat.

Our experience during the Thanksgiving, Christmas and New Year's holidays a year ago proves our theory. The menu given to the patients for their selection on these days included turkey, roast chicken, Long Island duckling, goose and steak. From past experience one would say that on such holidays everyone would select turkey, but our experiment does not bear this out as is shown by the statistics in the accompanying table.

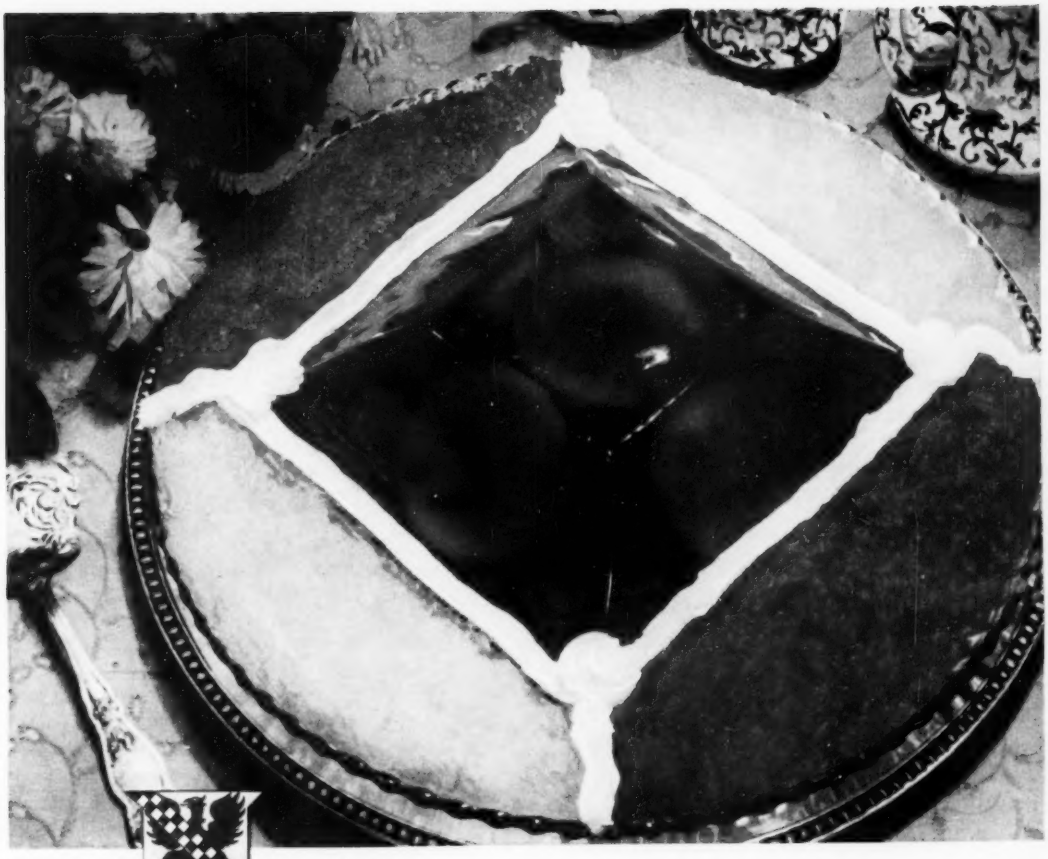
This analysis indicates that even on special days when the meals served are more elaborate the selective menus increased our patient good will because the patient had the right to select what he wanted rather than having our will forced upon him.

ORGANIZED NOURISHMENT SERVICE

The second change was not really a change but an improvement over what is customary in most hospitals with regard to between-meal nourishments. On studying our setup we found that some of our patients routinely received these nourishments whereas many others did not. In order to make our nourishment program beneficial to all, we started a cart service on which were placed all iced nourishments, such as milk, chocolate milk, tomato juice, pineapple juice and gingerale. This cart makes the rounds of the hospital twice daily at 10 a.m. and 3 p.m., and all patients who receive a fluid or general tray are visited and served whatever selection they may make. Seemingly, this additional service has not increased

Percentage of Patients' Selections From Holiday Menus

	Turkey	Roast Chicken	L. I. Duckling	Goose	Steak
Thanksgiving	95%	....	3%	....	2%
Christmas	90%	....	6%	4%	....
New Year's	....	60%	....	10%	30%



Good Food for Pleased Guests

Finesse...

It's wonderful, what you can do with Sexton gelatine desserts! Be as showy or as subtle as you please. Low in cost, they have irresistible allure . . . and the taste confirms what the eye foretells. Only the finest ingredients, the purest of true-fruit flavors are good enough for our label or for your table. Sexton instant pudding desserts have the same unsurpassed quality. Serve them often.

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1.

Great capacity in a small package—that's the Hobart AM-7 Dishwashing Machine. Here's a semi-automatic unit built to handle with ease the peak loads of every average operation—yet, its compactness in relation to its output is amazing. Performance, of course, meets the highest standards in effect today.

2.

Featuring a high speed wash, powered by a Hobart-built, ball bearing motor with high efficiency pump, the patented revolving wash headers of the Model AM-7 Dishwashing Machine quickly strip food from the dishes, and powerful wash streams thoroughly cover every point in the rack area. The rinse system directs water into every crevice—rinses the dishes rapidly, thoroughly, with maximum efficiency.

3. Check for yourself the scores of features that make this newcomer to the *complete* Hobart dishwasher line so amazingly effective. Like all Hobart products, it is built for years and years of superlative performance. Like all other Hobart products, too, *orders can be taken now for quick shipment.* See the Hobart line today—it's time to save time!

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THE HOBART MANUFACTURING CO., TROY, OHIO • Factories in Troy, Dayton, Greenville, U.S.A.

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our cost materially because nourishments were given in a haphazard manner previously, but even if this were not the case I believe that the favorable effect on public relations would more than offset any additional cost.

MEAL CHANGE

The third improvement made was to change our dinner meal from noon to evening. One of the gravest complaints we had had was that a light supper was not sufficient to carry even a sick patient over from 5 o'clock in the evening to 8 the following morning. This change has had a very favorable reaction from the patients. Some administrators may raise the question that a dinner meal in the evening will increase the labor load and cause apprehension and ill will among the employes because they may feel that they will have to work longer in the evening to finish. Up to this writing this has not proved true, for our employes are out of the kitchen at approximately the same time as they were under the previous arrangement.

Another innovation by our dietetic department was the establishment of special parties for patients who celebrate a birthday while in the hospital. We feel that this little personalized attention will build further good will.

In conclusion, may I stress the one fact that stands out from our experience, namely, that the patients and their friends and relatives now feel they are receiving greater personal service and are singing our praise beyond our sincerest expectation. They are giving full credit to a department which has always turned in a good job even under the severest handicaps. These loyal employes now bask in the sunlight of satisfaction in a job well done, as they justly deserve to do.

FOOD FOR THOUGHT

MANUAL OF SPECIFICATIONS FOR CANNED FRUIT AND VEGETABLES. *American Hospital Association,* 18 *East Division Street, Chicago* 10. 1948. *Pp.* 107 *and Appendix.* $2.50.

This extremely useful compilation was prepared under the auspices of the association's Council on Administrative Practice and Committee on Purchasing, Simplification and Standardization, aided by Margaret Gillam, dietetics specialist, "under whose diligent efforts the tentative manual has finally reached the status of a published volume." Designed primarily to serve as a guide to hospital purchasing agents, dietitians and administrators in the purchasing of canned fruits and vegetables, it will be of great value as well to all others concerned with the production, marketing and consumption of these canned products.

United States standards form the basis of the specifications listed, with added data from canning agencies and packers. Two excellent charts are included: a "Buying Chart" which gives summarized information from which written specifications can be made, and a "Serving and Cost Chart" which as the title implies gives serving yield per container and expedites cost comparisons.

Everything the food buyer needs to know, written in terms understandable to the novice, is given, and all canned items commonly used in the hospital kitchen are listed. Especially helpful to the inexperienced buyer who wishes to test products before purchase is the warning note which concludes the data on each item: "Watch for these irregularities that indicate poor quality." Then follows a listing of the characteristics commonly found in inferior samples of the type of product under examination. — MARY P. HUDDLESON.

PORTION CONTROL AND FOOD COST MANUAL. *By George L. Wenzel. Published by the Paper Cup and Container Institute, Inc.,* 1790 *Broadway, New York* 19.

Written by a former director of the American Restaurant Institute, now an associate professor at the University of Texas and a restaurant consultant, the information contained in this booklet is equally pertinent to any hospital operated on a business-like basis.

Food costs today, according to Mr. Wenzel, range from 40 to 55 per cent of the food dollar; the food manager in the nonprofit institution still struggles to maintain his 60 per cent break-even cost. Meanwhile the pay roll percentage has been stretching from 20 to as much as 35 per cent. Since the dollar won't stretch any farther, Mr. Wenzel maintains that the only answer is portion control, not necessarily by cheating the guest through serving minute portions at a high price, but by determining how much of each menu item can be served at a price in line with the food budget limitations of the nonprofit institution or the expected 5 per cent profit in the commercial restaurant.

Paper portion cups are used in showing portion costs for a great variety of foods. These cost charts range from appetizers, salads, sauces and relishes, fruits and vegetables to desserts and miscellaneous foods. The meat portion control chart is taken from "Wenzel's Menu-Maker." The author recommends the use of paper portion cups not only to control costs but to speed service, keep cold foods colder and hot foods hotter, ease dishwashing and breakage, and reduce labor cost.

Storage of Canned Foods

Cool rather than dark storage is important for keeping canned food at its best, according to scientists at the Massachusetts Experiment Station. Many tests at this station have shown that light has no effect on canned food but that the warmth of ordinary room temperature causes changes in color and flavor and loss of nutritive value.

Colored foods, such as beets and raspberries, stored at room temperature (70-80° F.), lost color and flavor, regardless of whether they were in the dark or on a shelf exposed to light. But these qualities were well retained when the products were stored at 42° F.

The scientists explain that oxidation —the action of oxygen in the air entrapped in the container—is what damages color and flavor and destroys some vitamins, especially vitamin C. Oxidation is increased and speeded up by warmth but retarded by cold. The warmer the storage, the more rapid the deterioration. All canned foods should be stored at temperatures below 70° F.

The new method of canning fruits with added ascorbic acid (vitamin C) is a great protection against damage from oxidation because this substance absorbs oxygen in the jar and prevents it from acting on the fruit. Even when ascorbic acid is used, cool storage is advised to protect the food.

Grass-Fed Beef

Lean, grass-fed beef animals that reach the butcher shops without being "finished" by weeks of feeding and fattening on grain save many tons of grain. The grass-fed beef rates as "Utility" grade, "Commercial" grade, or sometime up to low "Good" grade. Around three pounds of grain, on the average, goes into the production of each pound of Good grade beef, in addition to much hay, silage and grass. Nearly five pounds of grain is required for each pound of choice grade beef.

Although the grass-fed beef is less tender and less marbled with fat, it offers more protein than does beef of higher grade, and if properly cooked so that it becomes tender, its flavor is quite good, say home economists of the U.S. Department of Agriculture. Some of the steak and roast cuts from this kind of beef can be broiled or roasted like similar cuts from higher grades of beef, if care is taken not to cook them too well done so that they toughen, shrink and dry out. In general, however, the success rule for preparing lower grade beef is to cook it as less tender cuts of meat are regularly cooked.

There are two main ways of cooking beef from tough to tender. One way is to grind the meat. This cuts the connective tissue into small bits. After grinding, the meat can be broiled, pan broiled or baked, just as if it were a tender cut. The other way to make tough meat tender is to give it long, slow cooking with moisture, or faster cooking in a pressure saucepan. Pounding the meat before cooking helps to make it tender by softening the connective tissue.

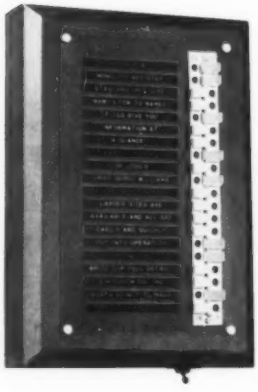
An extra aid to tenderness is adding some acid food like vinegar or tomato to the meat. Tomatoes may be used for the liquid in stews, pot roasts and Swiss steak. A little vinegar added to the water will help cook a pot roast tender.

Sweetness From Cold

Parsnips selling on fall markets often lack the fine sweet flavor of those served at fall and winter dinner tables on the farm. As a result city people may find them insipid and become prejudiced against them, scientists of the U.S. Department of Agriculture say.

The trouble with such market parsnips simply is that they have been dug too early for natural conditioning by freezing weather. Exposure to cold develops sweet flavor. On the farm and in home gardens the old practice is to leave parsnips in the ground and dig them as needed during the winter. Parsnips bought at stores in the fall may be improved by wrapping in waxed paper and leaving for some days close to the freezing compartment of the refrigerator.

The scientists explain that at low temperatures the starch in parsnips gradually changes to sugar, as it does in salsify and potatoes. This change is undesirable in potatoes but necessary for best flavor in parsnips and salsify. At least two weeks' exposure to a temperature around freezing is necessary for best flavor in parsnips and salsify. They can then be dug and stored if desired. Leaving them in the ground all winter long does no



How to avoid "manhunts"

Know who's in with MONOLITE REGISTER

Time is lost and tempers rise when, after a long search, you find the person you want has been out all the time. Couch Monolite Registers provide a simple, workable solution.

By simply flipping a shutter, a red or green signal light beside each name listed shows who's "in" and who's "out" . . . plug in connection . . . installed easily. Available in models listing names in multiples of 20 up to 80. Used in hospitals, clinics, professional buildings, and offices.

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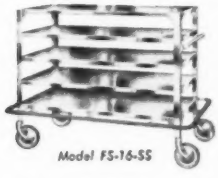
TRAY CONVEYOR...Electrically-Heated

Accommodates loaded trays. Keeps food hot and palatable. Fully welded construction in stainless steel or silvertone-finished steel.



Model FS-16-SS

TRAY SERVICE TRUCK

All stainless steel. Durably built for long and efficient service. Holds fifteen 16½" x 22½" or twenty 14" x 18" trays.

Model FS-32-SS

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Stainless steel construction. Attractive, modern design. Will withstand years of hard service. Removable trays.

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No. 18 gauge stainless steel — heavier than ordinarily used. Reinforced construction. Strong hinges.

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¼" thick extra heavy stainless steel. Positive protection for meat pan.

3 Strong LEVERS • Large PIVOTS
Sturdy levers and extra large pivots prevent binding or sticking of doors.

5 Stainless Steel BUMPER FRAME
Not ordinary iron. The heavy channel section and connecting spacers resist impact.

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Strongly reinforced. Edges will not dent and cause binding. Smooth, noiseless, disappearing action.

Model ALS-6271 Serves 45 to 60 patients

LOOK for these 5 features when you buy your next food conveyor. Only in "Conqueror" can you find such consistent craftsmanship in every detail of construction.

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OUTDOOR FOOD CONVEYOR

Completely welded stainless steel construction. Electrically heated. Body of conveyor mounted on tilt-type chassis with two large pneumatic wheels at center, one pneumatic swivel caster at push-handle end and one stationary caster at other end.

Model AHS-OUTDOOR-6271

harm and saves the time and labor of storing them.

Parsnips and salsify like other root vegetables are good energy foods, ranking along with potatoes for calories.

Saving C in Salad

Fresh, crisp, raw cabbage is one of the best and generally least expensive vegetables for vitamin C. But how much of this vitamin it has to offer by the time it is served in salad depends considerably upon how and when it is mixed, tests at the Maine and Utah experiment stations show.

The utensils used in mixing salad may affect its vitamin C content, according to the Maine scientists. Cabbage salad mixed in an enameled bowl with a steel kitchen fork lost almost 13 per cent more than that mixed in a glass bowl with a silver fork. Such metals as steel, iron and copper are especially destructive to vitamin C.

Last-minute mixing also is important for saving C. The Maine scientists advise adding vinegar or salad dressing just before eating, because as soon as the dressing is added, the cabbage begins to lose this vitamin. In the tests, shredded cabbage with French dressing mixed with a kitchen fork lost 35 per cent of its C within two hours, but shredded cabbage without dressing lost only 5 per cent.

If cabbage salad must be dressed in advance of serving, as is usually the case when it is prepared in large quantities in restaurants and institutions, keep it in the refrigerator, the Utah Station advises. In tests at this station dressed salad kept in the refrigerator until served had considerably more of its C than that which stood on the kitchen table at room temperature.

• • •

Manufacture of Fruit Essence

Apple and other fruit essences are now being produced by eighteen companies, using the simple recovery process developed a few years ago at the Eastern Regional Research Laboratory, U.S. Department of Agriculture, at Philadelphia, in the course of research on apple products. Thirteen of these companies are using the new process to recover essence from apples, grapes, pineapples and oranges for flavoring their own products.

Five companies are manufacturing essence for sale. Three of these are producing only apple essence. One concern estimates that it has a capacity for producing 35,000 gallons of essence annually from the 700,000 gallons of concentrate it plans to make from five million gallons of juice, using about a million and a half bushels of apples. Another plant, with an estimated capacity for producing 5000 gallons of juice daily, is recovering apple, grape, peach and cherry essences. Still another is experimenting with strawberry, pineapple, blackberry, apricot, cherry and peach essences on a small scale.

Aside from these companies, already in production, thirty-five others report that they plan to make fruit essence by this process as soon as they can obtain the necessary equipment.

Fruit essence is in commercial demand for adding flavor to a great variety of products—beverages, table sirup, ices, confections, jellies, preserves, sauces, gelatin desserts and pharmaceuticals. In the process, developed at the laboratory, the fragrant, flavorful vapors that rise during the heating of fruit juice are captured, then condensed and concentrated from 10 to 150-fold.

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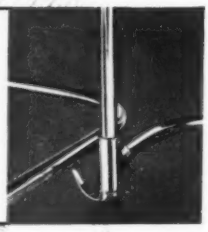

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Judd's strong, durable cubicle equipment is easy to install and maintain. And you can depend on Judd's efficient planning to use space to best advantage...keep costs at a minimum. For a costfree estimate, just send a simple diagram, with dimensions, of areas to be cubicled.

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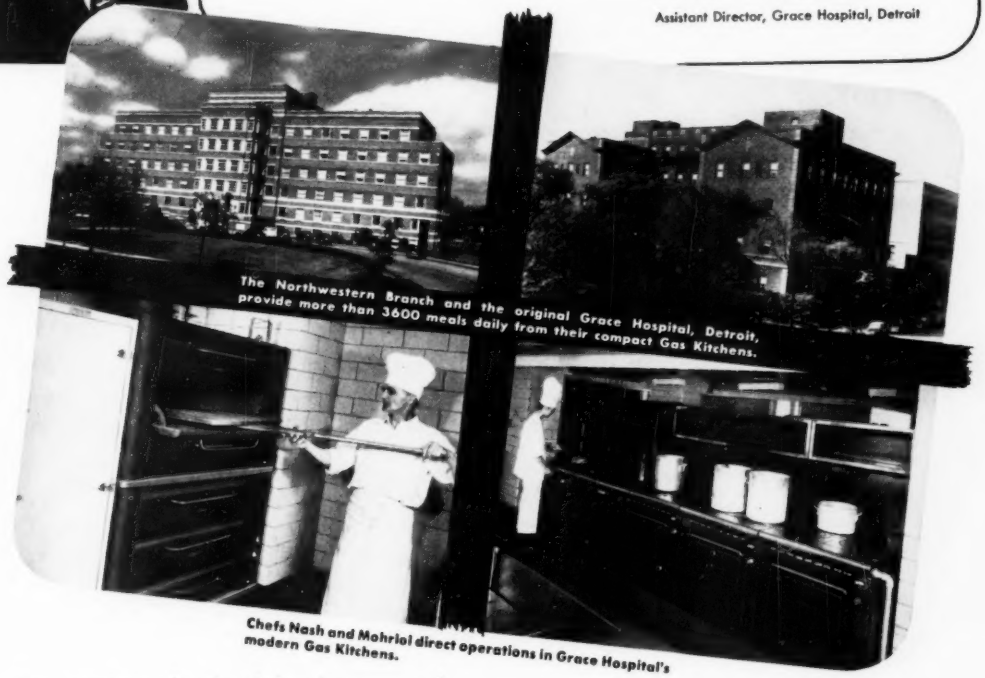
"GAS GIVES US THE SPEED, FLEXIBILITY, CLEANLINESS and ECONOMY WE DEMAND IN A FUEL FOR COOKING"

—Wm. F. Middleton

Assistant Director, Grace Hospital, Detroit



The Northwestern Branch and the original Grace Hospital, Detroit, provide more than 3600 meals daily from their compact Gas Kitchens.

Chefs Nash and Mohrlol direct operations in Grace Hospital's modern Gas Kitchens.

From management's point of view the economy of GAS is of first importance but Mr. Middleton speaks from the operating viewpoint as well when he stresses speed, flexibility, cleanliness.

There's authority in his statement, too, for Mr. Middleton is President of International Stewards' and Caterers' Association, and has had wide experience in volume food preparation.

The advantages of GAS and modern Gas Kitchen Equipment are matters of record in leading hospitals, schools and institutions. In establishments of this type the speed and flexibility of GAS are important factors in maintaining service schedules while simple, time-saving Gas Equipment helps overcome personnel limitations.

In every hospital, school, or institutional kitchen there's an opportunity for increasing food service efficiency with modern Gas Cooking Equipment. It's worth investigating.

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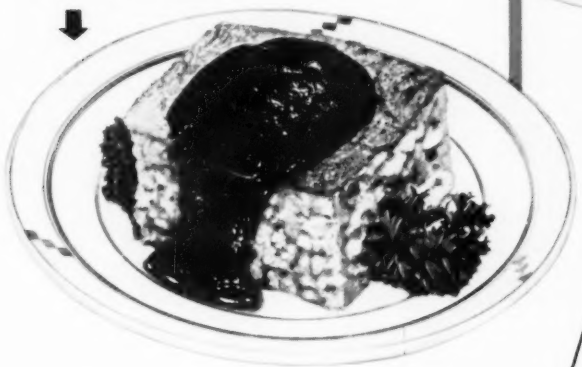
PEOPLE WHO TALK ABOUT GOOD FOOD . . .

talking about LOW COST MEALS

For lunch, instead of a meat dish: Try the special recipe for Blueberry Griddle Cakes, thriftily made with the aid of Calumet Baking Powder. Just what people like. And costs you less, especially if you serve money-saving Wigwam Syrup, rich with that delicious "close to Nature" flavor.

For supper, instead of a meat dish: Cut costs and enliven your menu with a Corn-and-Cheese Soufflé, and a side serving of tangy Snider's Catsup. Minute Tapioca, a "magic" stabilizing ingredient, tends to keep the soufflé from falling. Just the right sort of dish to stimulate appetites with extra color contributed by peppers and pimientos. Economical meat-saver.



For all meals, to cut costs and pep up menus: Menu suggestions above are only two of hundreds available to you through General Foods Quantity Recipe Service. Geared to please customers mightily and cut food costs delightfully.

Menu
Today's Suggestion

Hurry! Hurry! You can still enter General Foods 4 Big Contests and win Atlantic City trip or one of 28 valuable awards. Contest entries must be postmarked not later than Feb. 28th. For full details, see January, 1949, issue of this magazine or write: General Foods Institution Dept., 250 Park Ave., New York 17, N. Y.

...TALK ABOUT GENERAL FOODS!

Menus for March 1949

Rebecca Slatt
Memorial Hospital of Laramie
Cheyenne, Wyo.

1
Grapefruit
Egg Soufflé
•
Consommé
Roast Fresh Ham With Gravy and Dressing
Mashed Potatoes
Buttered Lima Beans
Apple and Celery Salad
Grapenut Custard
•
Cream of Asparagus Soup
Scrambled Eggs
Buttered Carrots
Spinach Salad
Blueberry Muffins
Fruit Gelatin

2
Sliced Oranges
Bacon, Toast
•
Barley Soup
Lamb Chops, Mint Sauce
Pimiento Potato Soufflé
Buttered Green Beans
Carrot and Raisin Salad
Banana Nut Ice Cream
•
Vegetable Soup
Tuna and Noodle Casserole
Buttered Peas
Lettuce, French Dressing
Canned Peaches
Peanut Butter Cookies

3
Pineapple Juice
Scrambled Eggs
•
Chicken-Noodle Soup
Meat Loaf
Parsley Potatoes
Candied Parsnips
Tomato Salad
Layer Cake
•
Cream of Corn Soup
Canadian Bacon
Baked Potatoes
Fruit Salad
Iced Cup Cakes

4
Stewed Prunes
French Toast, Sirup
•
Consommé
Baked Salmon Slices With Lemon
Potatoes Croquettes
Buttered Beets
Combination Salad
Cherry Cobbler
•
Tomato Bouillon
Escalloped Oysters
Buttered Asparagus
Perfection Salad
Bran Muffins
Chocolate Eclairs

5
Bananas
Soft Boiled Eggs
•
Alphabet Soup
Roast Prime Ribs of Beef
Browned Potatoes
Buttered String Beans
Tomato Salad
Fig Cake
•
Cream of Chicken Soup
Broiled Ground Beef on Buns
Buttered Carrots
Orange Salad
Brownies

6
Grapefruit
Bacon, Sweet Rolls
•
Rice Soup
Roast Turkey With Gravy and Dressing
Mashed Potatoes
Cranberry Sauce
Buttered Fresh Asparagus
Sunshine Salad
Vanilla Ice Cream
•
Cream of Tomato Soup
Link Sauages
Corn Fritters, Sirup
Banana Nut Salad
Lemon Snow With Custard Sauce

7
Blended Juice
Poached Eggs
•
Scotch Broth
Roast Leg of Lamb, Mint Jelly
Mashed Potatoes
Glazed Carrots
Grapefruit and Avocado Salad
Boston Cream Pie
•
Vegetable Soup
Italienne Spaghetti
Buttered Green Beans
Beet and Cucumber Salad
Canned Apricots

8
Oranges Halves
Bacon, Toast
•
Turkey-Rice Soup
Broiled Steak
Creamed Potatoes
Buttered Spinach
Mixed Green Salad
Chocolate Pie
•
Philadelphia Pepperpot Soup
Creamed Sweetbreads on Toast
Buttered Peas
Stuffed Celery Sticks
Fresh Fruit Cup

9
Figs
Scrambled Eggs
•
Consommé
Pot Roast of Beef
Browned Potatoes
Escalloped Tomatoes
Lettuce Salad, Thousand Island Dressing
Cherry Sundae
•
Cream of Celery Soup
Braised Liver
Potatoes au Gratin
Celery and Carrot Sticks
Bran Muffins
Canned Pears

10
Grapefruit
Link Sausages
•
Vegetable Noodle Soup
Roast Veal, Gravy
Parsley Potatoes
Buttered Fresh Asparagus
Orange Salad
White Cake With Orange Icing
•
Cream of Pea Soup
Salisbury Steak With Mushroom Gravy
Buttered Carrots
Tomato Salad
Tapioca Pudding

11
De Luxe Plums
Soft Boiled Eggs
•
Consommé
Broiled Halibut, Tartare Sauce
French Fried Potatoes
Buttered Mustard Greens
Tossed Salad
Rhubarb Cream Pie
•
Cream of Mushroom Soup
Scrambled Eggs
Buttered Green Beans
Hawaiian Salad
Strawberry Shortcake With Whipped Cream

12
Tomato Juice
Scrambled Eggs
•
Alphabet Soup
Braised Ribs and Noodles
Mashed Potatoes
Buttered White Squash
Pear and Cottage Cheese Salad
Spice Cake With Brown Sugar Icing
•
Cream of Tomato Soup
Noodle Casserole
Buttered Peas
Combination Vegetable Salad
Blueberry Muffins
Baked Custard

13
Bananas
Scrambled Eggs
•
Chicken-Noodle Soup
Baked Ham, Raisin Sauce
Candied Sweet Potatoes
Buttered Green Lima Beans
Perfection Salad
Chocolate Chip Ice Cream
•
Vegetable Soup
Chicken à la King on Toast
Baked Potatoes
Orange and Grapefruit Salad
Pineapple Icebox Cake

14
Grapefruit
Eggs à la Goldenrod
•
Consommé
Breaded Veal
Escalloped Potatoes
Buttered Beets
Spiced Pear Salad
Lemon Chiffon Pie
•
Cream of Chicken Soup
Individual Meat Pie
Lettuce, Thousand Island Dressing
Prune Whip, Custard Sauce

15
Bananas
Bacon, Toast
•
Barley Soup
Roast Prime Ribs of Beef
Whipped Potatoes
Buttered Spinach
Tomato Salad With Mayonnaise
Coffee Whip With Whipped Cream
•
Cream of Mushroom Soup
Baked Ham
Escalloped Corn
Combination Salad
Canned Apricots

16
Stewed Raisins
Raised Doughtnuts
•
Tomato Bouillon
Stuffed Pork Chops
Crabapples
Duchess Potatoes
Creamed Celery and Almonds
Spinach Salad
Strawberry Sundae
•
Cream of Vegetable Soup
Meat Loaf
Buttered Carrots
Hot Biscuits and Honey
Celery, Olive and Avocado Salad
Date Torte, Whipped Cream

17
Sliced Oranges
Scrambled Eggs
•
Consommé
Beef Stew With Vegetables
Coldslaw
Corn Bread
Peach Pudding With Cream
•
Scotch Broth
Spaghetti With Cheese and Tomatoes
Buttered String Beans
Lettuce, Thousand Island Dressing
Chocolate Cottage Pudding

18
Grape Juice
Poached Eggs
•
Alphabet Soup
Broiled Smelts, Egg Sauce
Baked Potatoes
Buttered Turnip Greens
Grapefruit and Orange Salad
Bread Pudding, Caramel Sauce
•
Duchess Soup
Salad Plate: Salmon Salad, Deviled Eggs, Tomato Salad
Bran Muffins
Strawberry Shortcake, Whipped Cream

19
Tangerines
Bacon, Toast
•
Vegetable Soup
Swiss Steak
Sweet Potato Croquettes
Stewed Tomatoes
Lettuce, French Dressing
Apple Pie, Cheese
•
Cream of Corn Soup
Hot Roast Beef Sandwich
Buttered Peas and Carrots
Celery Strips
Pineapple Cubes

20
Grapefruit
Soft Boiled Eggs
•
Consommé
Stewed Chicken With Gravy
Steamed Rice
Buttered Fresh Asparagus
Vegetable Perfection Salad
Peppermint Stick Ice Cream
•
Cream of Celery Soup
Broiled Lunch Meat
Buttered Green Beans
Banana Salad
Raspberry Bavarian Cream
Vanilla Wafers

21
Stewed Rhubard
Griddle Cakes, Sirup
•
Chicken-Noodle Soup
Pot Roast of Beef With Gravy
Mashed Potatoes
Buttered Summer Squash
Fruit Salad
Chocolate Torte
•
Cream of Potato Soup
Grilled Cheese and Bacon Sandwiches
Buttered Carrots
Cherries
Oatmeal Cookies

22
Grapefruit
Bacon, Toast
•
Rice Soup
Roast Veal With Gravy
Stuffed Potatoes
Buttered Green Beans
Tomato Salad
Pumpkin Pie
•
Vegetable Soup
Meat Croquettes With Cheese Sauce
Buttered Beet and Beet Greens
Tossed Salad
Hot Gingerbread

23
Bananas
Scrambled Eggs
•
Consommé
Broiled Steak
Escalloped Potatoes
Buttered Whole Kernel Corn With Pimientoes
Combination Fruit Salad
Vanilla Ice Cream
•
Hot Vegetable Cocktail
Creamed Ham on Corn Bread
Buttered String Beans
Tomato Salad
Canned Peaches

24
Apple Juice
Bacon, Toast
•
Mushroom Consommé
Stewed Chicken and Noodles
Mashed Potatoes
Buttered Spinach
Cinnamon Apple and Cottage Cheese Salad
Steamed Pudding, Caramel Sauce
•
Cream of Pea Soup
Porcupine Meat Balls With Brown Gravy
Buttered Peas
Coldslaw
Apple Crisp, Lemon Sauce

25
Sliced Oranges
Cheese Omelet
•
Consommé
Baked Haddock
Parsley Potatoes
Harvard Beets
Lettuce Salad
Mint Ice Wafers
•
Cream of Corn Soup
Baked Rice With Cheese
Stewed Tomatoes
Celery and Carrot Strips
Twin Mountain Muffins
Fruited Gelatine

26
Grapefruit
Grilled Ham Slices
•
Rice Soup
Veal Stew With Dumplings
Buttered Peas
Julienne Vegetable Salad
Pineapple Upside-Down Cake
•
Cream of Pea Soup
Braised Liver
Potatoes au Gratin
Asparagus Salad
Rice Custard Pudding

27
Pineapple Juice
Scrambled Eggs
•
Beef-Noodle Soup
Roast Fresh Ham With Dressing
Mashed Potatoes
Buttered Mustard Greens
Waldorf Salad in Lemon Gelatin
Caramel Sundae
•
Scotch Broth
Creamed Dried Beef
Baked Potatoes
Orange and Avocado Salad
Strawberry Shortcake With Whipped Cream

28
Apricot Nectar
Baked Eggs
•
Consommé
Lamb Chops, Mint Jelly
Oven Browned Potatoes
Escalloped Corn
Tomato Salad
Grapenut Custard
•
Tomato Bisque
Cubed Steak Sandwiches
Hot Potato Salad
Lettuce, Thousand Island Dressing
Apricot Whip

29
Stewed Prunes
Poached Eggs
•
Alphabet Soup
Broiled Steak
Creamed Potatoes
Buttered Beets
String Bean Salad
Maplenut Ice Cream
•
Vegetable Soup
Creamed Oysters on Toast
Buttered Peas
Pineapple and Cottage Cheese Salad
Peach Tart, Whipped Cream

30
Grapefruit
Soft Boiled Eggs
•
Consommé
Baked Cured Ham
Candied Sweet Potatoes
Buttered Spinach
Golden Glow Salad
Butterscotch Pie
•
Cream of Potato Soup
Italienne Spaghetti
With Tiny Meat Balls
Lettuce, French Dressing
Fruit Cocktail
Cookies

31
Sliced Oranges, Bacon, Muffins • Noodle Soup, Veal Shortcake and Biscuits, Baked Squash, Asparagus Salad, Three-In-One Sherbert • Cream of Chicken Soup, Cold Baked Ham, Candied Parsnips, Tomato Salad, Cup Cakes With Orange Icing

Ready-to-eat or cooked cereals are offered on all breakfast menus.

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Ac'cent, they find, makes foods taste better. Yet it isn't "artificial" in its effect or in its source. It adds no flavor, aroma, or color of its own. The flavors it brings out, emphasizes, are the natural flavors already present in the foods . . . the true, full flavors of the foods themselves.

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In a word, Ac'cent can mean more enjoyable food that keeps its good flavor longer. And that is an advantage of real importance in the hospital kitchen.

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Conducted by Alta M. La Belle and Jane Barton

EVALUATION Puts the Price Tag on the Job

HETTIE SMITH
Chief Analyst
John Hancock
Life Insurance Company
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IN PLANNING this discussion, I have attempted to pick out the highlights of job evaluation and salary administration in the hope of presenting a general picture of what it involves: some of the advantages and disadvantages and some of the pitfalls.

We might first of all ask the rather obvious question: What is job evaluation? To state it quite simply, job evaluation is a systematic method of determining the relative difficulty of each job within an organization and evaluating its worth to the organization—in short, putting a price tag on each job.

SALARY IS CHIEF INTEREST

We might next ask: "Why have job evaluation?" There is probably no single subject of greater importance and interest to both management and the employe than the matter of compensation. The salary program and the manner in which it is administered play a vital part in personnel management and in the ultimate efficiency and economy of operations. If the salary plan is sound and is impartially applied, it constitutes a major incentive to individual effort and good employe relations. Conversely, if the salary plan is unsound, all efforts of management to establish good relations, no matter how noble they be, are seriously undermined.

It does not take a vivid imagination for us to realize that the primary motivating factor in our working experience is the compensation we receive for our efforts. There are, indeed, other satisfactions which we derive from our work, and heaven help us if there aren't, but in the final analysis we work to be economically independent and thereby to gain economic security. Therefore, a prerequisite to sound industrial relations is that the individual employe should receive an absolute amount of money sufficient to sustain him and his dependents.

Another prerequisite of good employe relations is that the employe should feel generally satisfied with the relatonship between his income and the income of other persons performing the same class of work in the company and in the industry.

If an employe is satisfied that he is being paid a wage which is fair in relation to what fellow employes are paid, he develops a confidence in his management which is the greatest incentive an employer can offer. Even though the level of his wage may be slightly below that of other organizations in the community, he will more readily accept it if he has the assurance that he is sharing fairly in the total wage expenditure of his company.

From management's point of view, it is becoming increasingly important to be able to justify to its employes both its general wage policies and its individual wage payments. The pressures of collective bargaining and unionism make it imperative that management be able to justify its wage policies. The time for individual bargaining (which is a polite term for chiseling an applicant down to the lowest rate he will accept) and hit-or-miss determination of wages is past. It is only through a systematic method of wage determination that management can present to its employes an equitable wage and salary structure.

BOSTON UNIVERSITY PRESENTS:

This is the first of two sections of a lecture on job evaluation, merit rating and salary administration. Various methods of making job evaluations are analyzed in this article. Miss Smith's discussion of merit rating and salary patterns will appear in the March issue.

Another concern of management is that of cost control. Any good business firm must be able to predict in general what its operating costs will be. As wages and salaries constitute a large percentage of operating cost, it is wise for management to be able to analyze its salary expenditures. Job evaluation furnishes this answer.

Now that we have thought briefly of what job evaluation is and why it is desirable, let us think of how such a program operates. The first step is to have top management back the undertaking and vest full authority in the individual or committee that will be charged with the responsibility of the program. This is an important first step because the program is bound to meet pressures and disapprovals from different levels throughout the organization. Without the full support of top management, the program may become worthless.

MUST MAINTAIN PROGRAM

The next step is to decide who shall carry on the program. Many companies employ outside consultants. This is expensive, the current rate for analysts being $100 per day per man. Also, after the consultant has completed the initial evaluation, company personnel must maintain the program; hence it is felt wise, when possible, to have company personnel develop its own program.

All job evaluation plans in use today fall into one of four basic categories, namely, "ranking," "grading," "factor comparison" and "point."

The *ranking system* was the earliest method used. It is sometimes referred to as the card sorting system because all jobs are ranged from high to low like the cards in a playing deck. A committee is asked to read the descriptions and rank the jobs in an organizational unit in order of importance. This process is repeated for each department at intervals and the jobs are finally lined up in order of importance. The existing salaries for each job are

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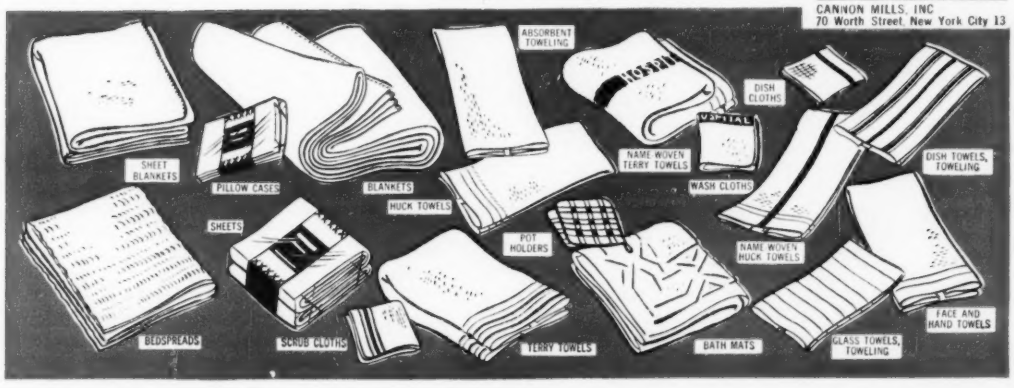

then studied; a survey is made of what other companies are paying for each job, and finally a logical salary progression is established.

The *grading system* consists basically of classifying jobs according to general types or levels of functions. The first step taken in such a plan is to study all jobs in order to determine the types of jobs existing in the concern and to define each type clearly. A committee then carefully reviews each job and places it in its proper grade by comparing the job description with the description of the grade. The following grades are typical: Unskilled, Skilled, Interpretive, Creative, Executive, Administrative and Policy. Once the jobs are graded, further refinement may be obtained by ranking each job within each grade. Minimum and maximum salaries are then assigned each grade and subdivided.

DANGER OF GENERALIZING

These two systems have the obvious advantage of being simple and inexpensive to administer. The disadvantages, however, are many. Inasmuch as no definite standards or criteria are employed for judging jobs, the final decision may be based on general impressions rather than careful analysis. Any explanation or justification of the final rate set is difficult to make to employes because there are no set rules or written records of the procedure. Despite these weaknesses, it is estimated that approximately 60 per cent of the jobs can be correctly evaluated. It must be remembered, however, that it is not concerning this 60 per cent of jobs that disagreement will arise but rather over the 40 per cent of jobs that may be out of line.

The *factor comparison* method is more detailed and systematic than are the ranking and grading systems and is used successfully by many large companies. This method determines the relative rank of jobs in relation to a monetary scale. Factors, or elements, of a job are selected, and from fifteen to twenty-five key jobs are ranked according to each of these factors. The going rate for these key jobs is then determined. This average current rate is then apportioned to each factor. For example, if the average rate paid a file clerk is $100 a month, what part of that amount is to be apportioned to the factor, "Mental Requirements," what portion to "Working Conditions"? If $35 is apportioned to "Mental Requirements" for a file clerk, how much should be apportioned to that factor for a typist? After the key jobs are ranked in proper order, they are used as bench marks between which the remainder of jobs in the organization are placed and with which they are ranked.

Obviously, one of the cardinal features of the factor comparison system is the distribution of the current wage paid the key jobs in order to develop the scale. However, many authorities feel that mingling money or monetary rates with the job evaluation procedure is undesirable since any inequity in the current wage paid will be reflected in the entire scale. In other words, this system presupposes that the current rates paid for key jobs are correct and bear the correct relationship to one another.

A *point system* consists basically of breaking jobs down into components or factors similar to those used in the factor comparison method and assigning point values to each of these factors. These point values are not related to dollars and cents. In most point systems the factors are fairly well standardized into: (1) skill, (2) effort, (3) responsibility and (4) working conditions. Each of these factors is divided into subfactors; for example, "responsibility" may be broken down

into responsibility for equipment, materials, work of others, safety of others, monetary responsibility. Each factor is now clearly defined into degrees, and points are assigned each degree.

The assigning of points is the most important step. Some factors are obviously more important than others and are therefore assigned more point value. For example, mental skill is more important and more difficult to buy on the labor market than is physical effort; therefore, it is assigned more weight. After the plan has been devised and tested and a job description has been obtained for each job, the analyst then evaluates the job by determining which degree of each factor is represented in the job and assigning the already established value for that degree.

These total points determine what labor grade the job falls into. Each labor grade has a predetermined minimum and maximum salary automatically assigned to it. This only briefly discusses the four types of job evaluation. It is difficult to determine which type is best to be used until the needs and conditions in a specific organization have been thoroughly analyzed.

However, irrespective of what plan is used there are certain principles which are fundamental to each.

Job Descriptions. Inasmuch as job evaluation is fundamentally the process of determining differences in jobs, it is obvious that, regardless of the specific evaluation plan used, jobs must be identified in such a way that any group reading the description can obtain a clear understanding of the work performed and can have in mind a uniform concept of the job. The job description may be thought of as the analyst's (or rating committee's) blueprint. Job blueprints may vary in complexity from short general statements regarding the principal duties and responsibilities to formal lengthy descriptions covering every aspect of the job. Certain items, however, should be included in every job description.

IDENTIFY JOB CLEARLY

Job Titles. The title should be as short as possible and should suggest the nature of the job. Job titles throughout various departments in an organization should be uniform. For example, individuals performing the work of a porter should not be called a porter in one department and a houseman in another department as long as they perform similar duties. Further identification information should be included which states the department and the division in which the specific job exists.

Purpose of Position or Job Summary. It has been found helpful to include in a job description a short introductory paragraph which states the purpose of the position and summarizes briefly the main duties necessary to fulfill that purpose. This short paragraph should be so worded that it distinguishes the description from that of similar positions and gives the reader a brief picture of where the job fits into the over-all pattern.

Work Performed. The most important part of the job description is that which describes the duties per-

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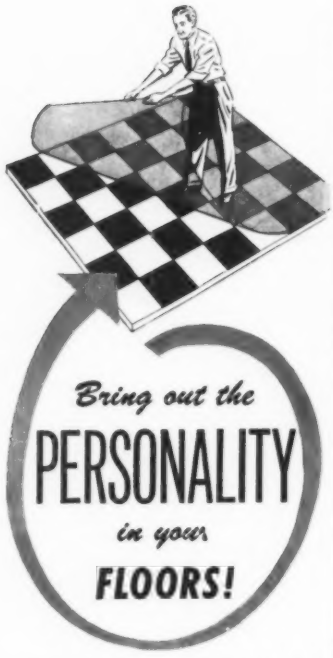

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formed. This section must include enough detail to give a clear picture of the work performed, but not so much detail that it becomes burdensome or confusing. Too much detail leads to endless controversies as minor changes are later made in the job. It is only through experience in writing job descriptions that one learns to include the important details and to state them clearly and concisely.

It is suggested that the various duties be listed under three headings: (1) daily duties, (2) regular periodic duties, and (3) occasional duties. The statement of each duty should start with a verb of action expressed in the third person singular, for example, *sweeps* floors, *maintains* records and supplies. Care should be used in choosing descriptive verbs which leave no doubt in the reader's mind regarding the scope of action required. As an example, "prepares laundry" may mean a variety of things. Does the employe sort the laundry, stamp it, bundle it up or actually wash it? When any such general verb is used it should be further substantiated by a description of what is involved, *i.e.* "prepares laundry for collection by sorting and maintaining record of items sent out," or "checks laundry upon return to ensure inclusion of all items." The principal and most important duties should be described first and in order of the flow of work. It is suggested that each important duty be described in separate paragraphs bearing individual underlined headings indicative of the work performed.

Estimates as to the average portion of time spent on each duty should be included. The amount of time may vary at specific times, but a general average may be approximated. As an example we may say: "Spends approximately 10 per cent of time checking laundry lists."

Another important aspect of describing the work performed is that of supervision. The description should clearly state whether the work is closely checked, spot-checked, or whether the work is done independently without check.

When an adequate description of the actual work has been made some reference should be made to the equipment or tools used in the performance, especially when a skill or physical effort is required to operate the equipment. Some reference should be made to working conditions or hazards, inasmuch as unpleasant or hazardous working conditions tend to make a job undesirable and hard to fill and, therefore, more expensive in the labor market.

A short statement of the requirements necessary to perform the job should be included. This statement should include reference to any special skills, education or experience requirements, physical requirements, and special personal or technical requirements.

The date on which the description was written should be recorded in a conspicuous place.

Once the decision has been made as to the general content to be included in the description, the next step is the determination of the best method of obtaining the information. The most thorough and satisfactory way is through a personal interview with the employe and further discussion with the supervisor. The analyst should observe the work being done and should ask leading questions of the employe in order to determine the exact nature of the work performed and the responsibilities involved. The job description should then be checked carefully by the employe and by the supervisor to ensure accuracy of facts. Many employes have a tendency to overestimate or underestimate the importance of their jobs. Therefore, a check by the supervisor is desirable. After the descriptions are written and checked, the jobs may be evaluated according to the plan established for doing so.

Once the jobs are evaluated, what does one do with these price tags? As previously stated, minimum and maximum salaries are established for each labor grade. Ideally, all persons who are being paid less than the minimum of their labor grade should be increased to the minimum or to the point within the range they should occupy. This depends, of course, upon the cost to the organization and its financial ability to incur the added expense. Those individuals who are being paid more than the maximum of the labor grade should not be decreased in pay. This should be made clear to all employes at the time the plan is undertaken. An effort should be made to place these employes in jobs of higher classification in which they may eventually qualify for additional increases. However, in some instances it is impossible to upgrade these employes of long service. They should continue to work at the same rate of pay and receive no subsequent increases.

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The entire shop has white walls and ceiling. The work bench, backboard, cabinets and stock racks are painted a light gray, trimmed in black. All tool handles are painted black.

The stock bins are for storing plumbing and electrical supplies. The supplies are separated in regard to size and type, each having its own bin. A few bins are used for large bolts, while small bolts and screws are stored in small drawers with a sample of each fastened to the face of the drawer.—LESTER ZWEIGE, *engineer, Margaret Mary Hospital, Batesville, Ind.*

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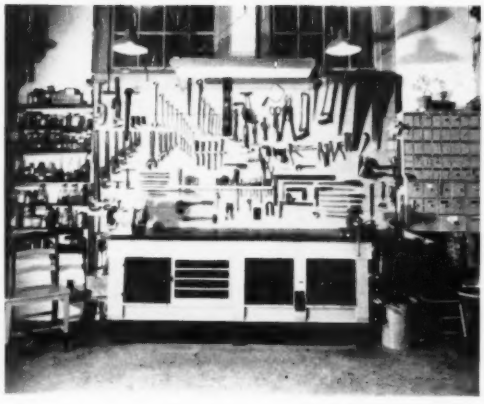

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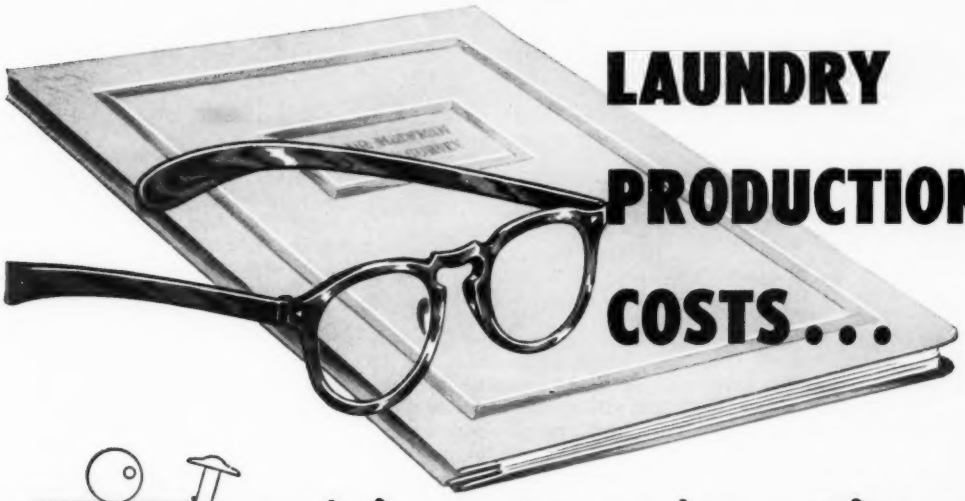

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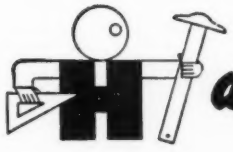

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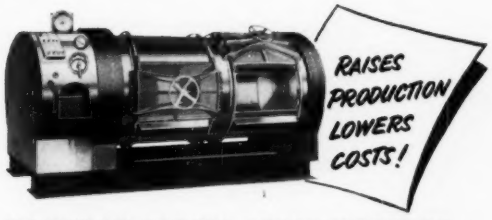

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WHO'S EXPLOITING WHOM?

(*Continued From Page* 50.)

this new plane, I put down one additional x-ray technician and one additional radiographic room which will have to be equipped. It seems to me that otherwise you can handle the load, the additional load quite well. How about it?"

"Well," I said, "the first question that arises is, how about myself? Do I get the same salary for serving that many private beds as I am getting now?" The superintendent didn't know that I brought a large amount of private practice from office buildings downtown and from doctors outside who were sending work out there. He assumed that every bit of the work that came there was work for Stanford and that I was the lucky guy that was getting the salary.

"Well, now," he said, "yours is one of the largest salaries in the institution. There is no thought of increasing your salary." That was when I handed in my letter of resignation.

MR. CUNNINGHAM: Is the thing that was wrong about that situation, in your opinion, the system, or was it an abuse of the system? A failure to recognize that additional responsibility should be rewarded by additional income is, I consider, an abuse of the system. Where is the evil?

DR. CHAMBERLAIN: I think it is the system, and I will tell you why. I will use this piece of paper. I am going to put three circles on this piece of paper. One of these is the hospital, one is the patient, and the third is the radiologist. Now, I think it is wrong for the patient's fees to go to the hospital, with the hospital retaining part and sending part on to the radiologist. I think that's the wrong direction for the money to circulate in.

MR. CUNNINGHAM: Why?

DR. CHAMBERLAIN: Because it leads to just exactly the misapprehensions which my friend, the hospital superintendent at Stanford, had —the feeling that the services of the radiologist are different from what they actually are.

MR. CUNNINGHAM: Does that follow? Does the misapprehension come from the circumstance that you outline, or does it come from the failure of that person to understand what those complicated relationships are?

DR. CHAMBERLAIN: I really think it is inherent in this diagram. Suppose the patient pays the radiologist, and then the radiologist pays plenty of that to the hospital. That creates the right kind of patient-radiologist relationship, because the patient knows who his radiologist is, he realizes that a professional service has been rendered to him, and that there is at least something comparable with the practice of medicine in the practice of radiology.

Now, I'd like to tell a story, a true story. I'll use fictitious names, but otherwise I'll tell the story just as it happened. When I moved to Philadelphia in 1930, one of the first people I met there was Jim Smith. At that time he was operating the tail end of a manufacturing business which was being sold out, and in the course of time, while we were still coming out of the depression, the job that had kept Jim Smith a going concern dwindled out, and here he was —

MR. CUNNINGHAM: It was a thing that happened from time to time in those years.

DR. CHAMBERLAIN: Yes. He was unemployed. Friends of his went to the superintendent of one of our fine Philadelphia hospitals and said, "You need an assistant and we have got just the man for you." Jim Smith went there as assistant superintendent. Four months later he came into my office, sat down and said, "Ed, I have just made a most astounding discovery. I have discovered that we are paying our radiologist $12,000 a year for the practice up there. I am sure that you have several of your younger men who would do the job just as well as that old gentleman, and you certainly must have somebody that would be glad to get the job for $5000 or $6000 a year, saving the hospital $6000 or $7000 a year."

"Well," I said, "Jim, that isn't exactly what is going on. You haven't got the figures exactly right. I happen to know that the patients are paying $24,000 a year for the radiologist's services, and Jones, the radiologist, is allowing the hospital to have $12,000 of that as recompense for all the services rendered by the hospital."

Jim said, "Why, no, it isn't that way at all. The patients pay the hospital $24,000 a year, and we have been paying Jones $12,000 and obviously that's too much, because obviously we could get it done for less money."

Well, now, when I had finally got it through his head, I said, "Hospitals can't practice radiology because the practice of radiology is the practice of medicine, and the hospital isn't in a position to practice radiology on those patients. The money that those patients are paying is really for Jones' services; he's the only radiologist there."

He said, "If that's true, Jones is very foolish because look at the impression it makes on the patients and on me and on everybody, if the patients are paying the money to the hospital instead of to the radiologist. Now that you have explained it to me, I would say that Jones should collect the fees and pay the hospital its share, instead of the hospital collecting the fees and paying Jones his share." I agree with that. At that moment, he saw the point that I'm trying to make here.

MR. CUNNINGHAM: Isn't the thing that is wrong only that a lot of people don't see the point, rather than that the money is paid in the wrong direction?

DR. CHAMBERLAIN: All right. But isn't it true that it is awfully easy for people to get the right impression if the flow of money is from patient to doctor and then from doctor to hospital, whereas it is awfully easy for them to get the wrong impression where the flow of money is from patient to hospital and from hospital to doctor?

DR. LITTAUER: I would like to ask a question tied in with that. If a

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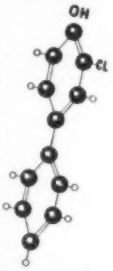

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radiologist collected his own fees and then gave the hospital a percentage of them, would that ensure any greater security for him than if the hospital collected it?

DR. CHAMBERLAIN: Yes, it does. In the first place, it establishes his relationship to the patient as that of a doctor rather than an employe of the hospital.

MR. CUNNINGHAM: Let me ask you something about that, Dr. Chamberlain. I don't quite understand why it is as important to me as a patient as it is to you. I can understand why it is important to you, but I don't get why it is important to me.

DR. CHAMBERLAIN: The question that we are trying to answer isn't a question as to what difference it makes to the patient. We are talking about the security of the radiologist. It gives the radiologist —

MR. CUNNINGHAM: Yes, but underlying this thing is the care of the patient. That's the objective with all of us.

DR. CHAMBERLAIN: Yes, indeed it is.

MR. CUNNINGHAM: And the security of the specialist, like the security of any professional man, as we have agreed, lies in his competence. His success is determined by the quality of care that he renders.

DR. CHAMBERLAIN: Yes, that's right.

MR. CUNNINGHAM: Not by his identity with any one or another group, right?

DR. CHAMBERLAIN: Don't you follow me, that when I bill a patient and the patient pays me, I have a more direct responsibility to that patient than I have under any other system of collection of the fee? Isn't that what we are talking about all the time with regard to state medicine, and socialization of medicine, and compulsory health insurance and so forth?

MR. CUNNINGHAM: It is what we are talking about. We condemn socialization because it does something to the patient-physician relationship, but I believe, from my experience as a patient, that the patient-physician relationship, as far as certain specialties are concerned (and again it is nobody's fault; it is just circumstantial), doesn't exist. In the sense that we are talking about it here, socialization already has occurred in your specialty and in Dr. Wood's specialty, in the sense that socialization means impersonalization. The thing that I would like to hear clarified is, why is that bad?

DR. CHAMBERLAIN: Well, I'll tell you why it is bad. When a patient at Temple University Hospital is dissatisfied with the services rendered, the amount of his bill, or anything else, he knows who to kick to. It is up to me to see that he gets proper service and proper care, because I do enter into a contractual relationship with him under our arrangement.

MR. CUNNINGHAM: If I am not satisfied with something that happened in the radiology department, isn't the fellow I complain to my own doctor, the man who brought me in there?

DR. CHAMBERLAIN: I think very likely so.

MR. CUNNINGHAM: And isn't that chain of responsibility just as strong, or perhaps even stronger, because my doctor can then go to you and demand satisfaction on a professional level?

DR. CHAMBERLAIN: Yes.

MR. CUNNINGHAM: —a level that I wouldn't comprehend. I believe that strengthens rather than weakens the chain of responsibility, because you are responsible to your professional peer, as well as to the patient you are taking care of.

DR. CHAMBERLAIN: Don't you think that my feeling of responsibility is different from that which I would have if I was on a salary basis, for instance?

MR. CUNNINGHAM: Well, I don't know, Doctor. I'd like to hear you discuss it.

DR. LITTAUER: Why should it be different?

DR. CHAMBERLAIN: Well, I feel different about it. I can assure you that when I submit a bill to a patient, I consider that I am entering into a contractual relation, that I have got to deliver the goods, and I am personally responsible for delivering the goods.

MR. CUNNINGHAM: Dr. Wood, do you think that the pathologist who is not on a fee basis has that feeling of responsibility for his performance? Isn't this something that should be non-fiscal in nature?

DR. WOOD: He starts out that way, but the human equation cuts across, and pretty soon he's less and less responsible.

DR. LITTAUER: Does that apply if he gets an equitable salary and if he's really interested in his work as a member of a team to care for the patient?

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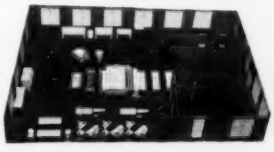

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DR. WOOD: If the pathologist or radiologist is on a basis where he feels he is not being exploited, and if he is well trained and stays sober and what not, the security rests on his ability to produce—

MR. CUNNINGHAM: To satisfy the physicians with whom he is associated.

DR. WOOD: And render good service to the patients.

MR. CUNNINGHAM: But the chain of responsibility there is through the physicians with whom he is associated.

DR. WOOD: We do our best work when we don't have security, when we have to stand on our own two feet and deliver the goods. But if you feel you are being exploited, that is totally different.

DR. LITTAUER: We aren't talking about exploitation.

DR. WOOD: No, but it enters into this matter of security. If it wasn't for the feeling of exploitation on the one hand, we wouldn't be here talking.

DR. CHAMBERLAIN: I think that is true, because in those instances we have talked about, the end was exploitation. The man who was building up something was kicked out and replaced by a man who was willing to accept a much smaller recompense for taking over that position. Somebody asked me what difference does this matter of the flow of money from patient to doctor instead of from patient to hospital make. Let me point out the fact that the radiologist or other hospital physician who is on the basis of collecting his own fees has an income which is not a matter of record with everybody around the hospital, and that in itself brings a certain measure of security. The man who gets a finger pointed at him and is told that he is making too much money is the man whose income is known.

The surgeon, for instance, doesn't have to contend with that. We know that in a general way the surgeons have large incomes, and we know that particularly successful surgeons have very large incomes, but nobody knows exactly what the income is.

DR. LITTAUER: Dr. Chamberlain, you mentioned one reason why you moved, and it was that you were told that even though the work of the hospital increased and the work of your department would increase, your own income would not increase with it. Now, suppose you had continued to be paid on a salary and that salary had been increased equitably, in proportion to the increased income of the department. Would that have had some influence on your decision to remain or not to remain?

DR. CHAMBERLAIN: It would have, except for one thing. The thing that really upset me wasn't just the one thing that happened to me, but it was that coming on top of the half dozen other instances which had happened in the years 1920 to 1928. If all hospitals were fair to their radiologists and other practicing staff members of that type—we'll call them, what shall we say, radiologist and anesthesiologist —

MR. CUNNINGHAM: I'd like to call them the hospital specialties, but I'm afraid I'd get my throat cut!

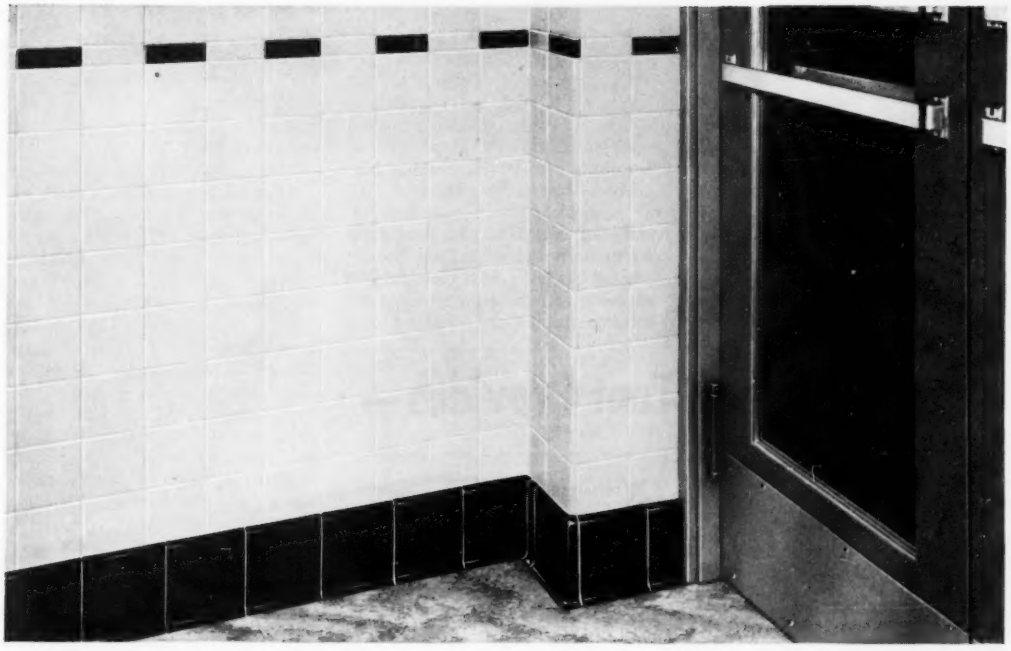
DR. CHAMBERLAIN: If hospitals were fair, if certain things that scare the daylights out of us were not being done, then I think this would never have come up, because I personally for years and years was perfectly content, and the fact that Stanford came out with more money than it needed to run the department didn't worry me.

MR. CUNNINGHAM: Then what you are saying is that it isn't the principle here, it's the abuse of the principle, that is bad. Isn't that it?

DR. CHAMBERLAIN: Well, on the other hand, I have been led through the years to believe that the principle itself leads to its abuses, and that if the principle under which I practice now doesn't lead to that abuse—

DR. LITTAUER: Dr. Chamberlain, I am familiar with several cities and a number of hospitals in those cities, and in all of the hospitals, the pathologists and the radiologists and the doctors of physical medicine have all had and still enjoy very long tenures, lasting over fifteen, twenty, or twenty-five years, and are honored and respected members of the staffs of the hospitals and of their communities. I am not aware of the great number of instances of exploitation of the type that you mention. Undoubtedly there are some examples of it, but it is my belief that they are the exception rather than the rule.

MR. CUNNINGHAM: Dr. Wood mentioned that where responsibility is through a hospital or another staff member rather than direct from physician to patient in these specialties, the tendency was for the specialist to rest a little bit on his laurels, not to do good work. Maybe that's why some of them leave. I mean, maybe there is fault on both sides in these circum-



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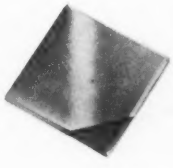

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stances that you mention, where all of a sudden the fellow is called in and told, "Look, no more."

DR. CHAMBERLAIN: No question about it. There is plenty of fault on both sides. But I want to point out this: There is fear among doctors, and particularly among radiologists and some of the laboratory specialists, of this specter of hospital domination over the practice of medicine. Now, maybe it's—

MR. CUNNINGHAM: What is meant by hospital domination over medical practice — other than this thing we have been talking about here today?

DR. CHAMBERLAIN: All right. When we meet together and talk things over, a radiologist says to me, "Gosh, my hospital has put in this terrible, all-inclusive rate structure which means that the patient pays a bill which includes his hospital bed and board and all the x-ray work that his personal physician can think of asking for and all the laboratory work and so forth and so on, and already I am in this fix: I need more help; I am doing twice as many stomach examinations as I ever did before, and I can't do a good job. I can't do as good a job as I used to do, and what in the world can I do about it? I can't budge them." They are bound and determined to try this experiment, and it is working out very badly from my standpoint."

MR. CUNNINGHAM: Let's look at it from another standpoint. Let's assume that here is a situation in which everybody wants to be fair and do the right thing—hospital, doctor, everybody. I am there as a patient, and my physician knows that I have limited means, and he kind of hesitates to cause me any extra expense, but on an inclusive rate he may be disposed to do a more complete work-up. Now, is that a possible result? I mean, could the inclusive rate result in better care for the patient, because it might to some extent diminish an economic barrier to complete care?

DR. CHAMBERLAIN: In my opinion, it doesn't work that way. In order to make it work that way, I am afraid it would be necessary to rebuild —

MR. CUNNINGHAM: Rebuild human nature?

DR. CHAMBERLAIN: Rebuild human nature.

MR. CUNNINGHAM: Well, it is not a bad idea.

DR. WOOD: Your costs would go way up in the long run.

MR. CUNNINGHAM: What is the explanation of the fact that a hospital adopts an inclusive rate, and on substantially the same number of admissions, then does many more radiographic and pathologic examinations? That has been the case. Is that simply because, "What the hell, it's free" and —

DR. CHAMBERLAIN: I think so.

MR. CUNNINGHAM: You do?

DR. CHAMBERLAIN: I really do.

MR. CUNNINGHAM: You think it is a more or less frivolous thing?

DR. CHAMBERLAIN: Well, I am sorry to admit it, but I do find that there are doctors who let their patients be kept busy and entertained in various departments, including the x-ray department, especially when it doesn't cost the patient additional money.

DR. WOOD: I'd like to answer that point too. I think it makes for much poorer medicine and much less cerebration on the part of the referring doctors. They are getting something for nothing, and it lowers the esprit

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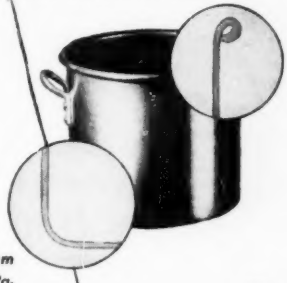

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de corps and the morale among the workers in the x-ray department.

MR. CUNNINGHAM: Because of an increased load?

DR. WOOD: Not only because of the increased load. That isn't so important as is the sense of futility that a lot of normals are being done. I was in a hospital once where men could order anything they wanted. A whole series of requests came in one day, for eighteen procedures, and I thought, "Gee, that's a very interesting case. I will call the medical officer right away." I called him. "How's your patient?" "Well, Doc, I haven't looked at him yet. I am waiting for the lab work to come back." That's the way it works so frequently. They practice medicine in the laboratory and the x-ray department, instead of out of their heads.

MR. CUNNINGHAM: But is that fact substantially changed by the fiscal arrangement?

DR. CHAMBERLAIN: Oh yes, I am sure it is.

DR. WOOD: Yes.

DR. CHAMBERLAIN: There is no income for the x-ray department when you have an all-inclusive rate structure. It is whatever the hospital management chooses to place it at. If the hospital is in financial difficulties, the radiologist and the laboratory physician are under pressure, because it is harder to get help. The management wants to give them help, but of course, if the hospital is unsuccessful, in the long run I'm in trouble. Even the man who has a fee arrangement. You can't be a part of an organization that is going to pieces, a ship that is sinking, without being just one of the rats on that ship.

MR. CUNNINGHAM: When you talk about an unsuccessful hospital, you mean unsuccessful financially rather than professionally?

DR. CHAMBERLAIN: Yes, that's what I mean.

MR. CUNNINGHAM: And that today has not much relationship to professional success, has it? I mean, you have the Johns Hopkins, the New York Hospital, others—there's where the big deficits are today.

DR. CHAMBERLAIN: The point I want to make is the physician who makes his living by collecting fees from the patient isn't put under the kind of squeeze that the radiologist or laboratory physician is under a Blue Cross plan or anything else when the hospital begins to have difficulty. For instance, this is the thing that worries us. A friend of ours resigned his position as the head of a department of radiology in one of the big teaching institutions for the reason that he was unable to make a success of it, and why? He said, "Well, every time I get a secretary that amounts to anything, the surgeons or the internists take her away from me because they can pay her more money than I can pay her." And that situation where his best technicians were always taken away from him by a private doctor who could pay more, and his best secretaries were taken away from him, resulted ultimately in his resigning.

MR. CUNNINGHAM: That's a fringe problem.

DR. LITTAUER: I would say the physicians did not have respect for the hospital specialist concerned if they raided his department.

DR. WOOD: I'd like to come back to some fundamentals here that I think tie in to a lot of these things on the periphery. In the first place, primary function in the practice of medicine is to give the best care pos-

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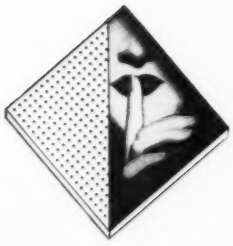

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sible to the individual. The point of view of the hospital is to provide the best hospital care, plus the facilities for the availability of radiology, pathology, anesthesiology. About the only way I can see that the problems pertaining to pathology and radiology and the others can be settled is for hospitals to let concessions to the respective physicians, and those people who are going to practice those specialties in those concessions should be selected on their merit, or professional ability, with the advice of the medical and executive staff.

It is a fundamental principle in the practice of medicine that the physician has to be free and unfettered in rendering his service to a patient. When you hire a man on a salary, whether he is a doctor or not, you invoke the master-servant relationship. You have a third party. He cannot be unfettered. This has been particularly true in the practice of pathology in the United States. Pathologists on salaries aren't able to have enough technicians. They aren't able to pay adequate salaries to get competent technicians. That all results in poorer medical care for the public, the patient that we are primarily interested in.

MR. CUNNINGHAM: But is that because of the salary? Is it because the pathologist is paid a salary that the technician isn't paid enough? Is there a relationship there?

MR. WOOD: It is very difficult to break that down.

DR. CHAMBERLAIN: No, it is an obvious relationship. A friend of mine is forced to run his department with inadequate personnel because there isn't money enough made available to him to keep his department on a high plane.

MR. CUNNINGHAM: If they are not giving you enough to run your department the way you think it ought to be run—

DR. CHAMBERLAIN: What should I do about it?

MR. CUNNINGHAM: That isn't because you are getting paid a salary, is it?

DR. CHAMBERLAIN: Yes, because—

MR. CUNNINGHAM: That's because somebody doesn't understand how that department should be run.

DR. CHAMBERLAIN: But if I collect the fees, then I am a free agent and I turn around and spend that money.

MR. CUNNINGHAM: What if you were a different kind of man and wanted to keep it for yourself and not spend it for another technician?

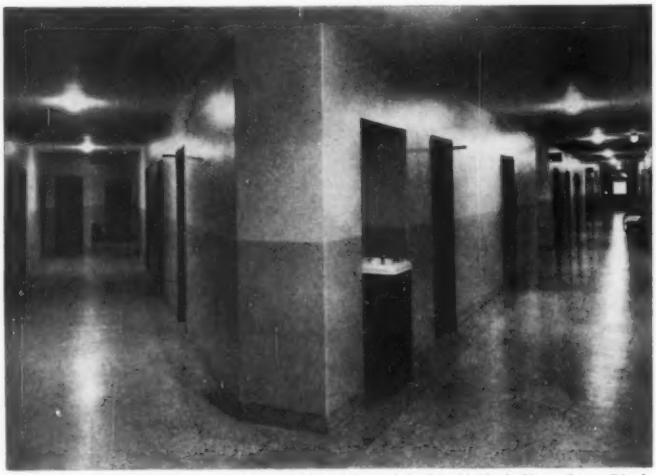
DR. CHAMBERLAIN: Then I should be kicked out. That's the answer.

MR. HAYT: Is it possible that the income of an x-ray department which is excessive is due perhaps to the exploitation of the patient; that he has been charged too high rates for what he gets?

DR. CHAMBERLAIN: Yes, I am sure that happens many times, and it is most apt to happen—

MR. HAYT: And would you favor reducing the rates or giving the excess to the radiologists?

DR. CHAMBERLAIN: I certainly wouldn't want to give it to the radiologist, because obviously if there is a surplus, if the patient is paying big fees and getting poor service, then the radiologist is the party to blame, but the first thing to examine is: Are there enough radiologists to handle that volume of business? The second thing to look into is: Are the technicians the best that can be obtained? Are they being properly compensated? And the third thing is, are the other employes



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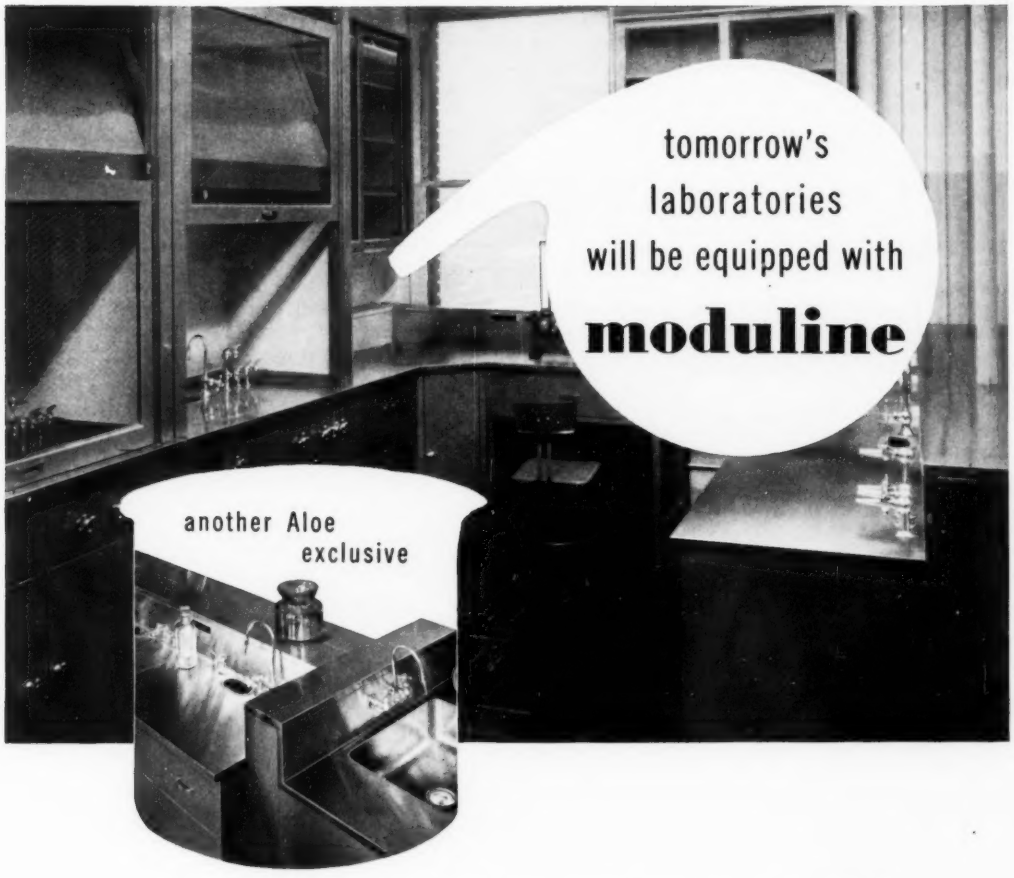

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in the department and the apparatus being kept up? Are they spending enough money on the department?

The gross income at my place is large, and the net income is small. The gross income is large because we do a great deal of work and see a great many patients, but the net income is to me very small.

MR. CUNNINGHAM: Because you spend a lot of money giving good care?

DR. CHAMBERLAIN: Because I spend a great deal of money. I spend what is necessary to bring in enough talent of all kinds and enough of everything that we need to do a good job.

MR. HAYT: Dr. Chamberlain, you complained about the fact that the radiologist's income is generally known to his colleagues, whereas the income of the surgeon is not known?

DR. CHAMBERLAIN: Yes.

MR. HAYT: Now, if the radiologist collects the fees directly from the patient, then the income of the radiologist would have as much secrecy as that of the other members of the staff?

DR. CHAMBERLAIN: That's right.

MR. HAYT: Well, now, how would the hospital know whether or not the patients are being exploited by excessive fees if the income of the radiologist is a secret?

DR. CHAMBERLAIN: Well, I suppose they would have no definite way of knowing. They know what the fee structure is; they know what the patients are paying in that sense, but I don't suppose they'd have any idea, except that in some sort of way, very subtly perhaps, the people at Temple know that Chamberlain is not exploiting the patients and is not exploiting anybody. As a matter of fact, most people think that I have a larger income than I have, but there is an awful lot of difference to me between having an exact figure that is advertised and is well known, and an income which is a fee for services.

MR. CUNNINGHAM: I'd like to pick up the point that Dr. Wood made about the impossibility of practicing unfettered medicine on a salary. Does that mean that unfettered medicine can't be practiced at the Cleveland Clinic or at the University of Chicago, or—

DR. WOOD: It may be, because emphasis is placed upon the number of procedures and not the quality. I pointed out that where you have master-servant relationship, with a pathologist on a salary at a private hospital, you have poor work. I can document this nationwide with innumerable examples, and the laboratories are making thousands and thousands of dollars in some instances. Pathologists are denied the right to hire or fire the technicians. You have no control over the people you are responsible for; you have inadequate salaries for technicians; inadequate secretarial help—go right on down the line. You frequently find a pathologist doing skimpy, superficial work; he's a harried individual, not infrequently down punching the typewriter, typing his own autopsy reports.

So what has happened? This is well known among younger people going into medicine. We have a critical shortage of pathologists, and it is getting worse instead of better. We have something around 1200 certified pathologists in the United States—not even one pathologist for one approved hospital. Then on top of these hospitals, we still have the smaller hospitals that are covered in a superficial way or not at all, in which John Q. Public is suffering because he is not getting good pathology services.

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2. Rose, M. S.: Rose's Foundation of Nutrition, rev. by MacLeod and Taylor, Macmillan, 4th ed., 1944. 3. Sherman, H. C.: Chemistry of Food and Nutrition, Macmillan, 7th ed., 1946.

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MR. CUNNINGHAM: What's the remedy?

DR. WOOD: I think the remedy is to allow the pathologist to be a free man, and I think that comes back to the concession again. If it is shown, with a fee schedule that is public, that he is making too much money, then either there is need for an additional pathologist or pathologists in the clinic; or there should be a reduction in the fee schedule.

MR. HAYT: Dr. Wood, would you mind telling us what you understand a master and servant relationship to involve? What do you mean by that?

DR. WOOD: Well, for example: You are a pathologist on a salary. You have got a good technician, and you are told you can pay her $200 a month, and you know downtown she can get $300 a month. The man from the front office says you can't pay anything more. You have no control over that person at all, and she moves on to another job.

MR. HAYT: Is that what you mean by master and servant relationship?

DR. WOOD: That's part of it.

MR. HAYT: Would you say that it includes direction on the part of the hospital as to how to diagnose or whom to diagnose, and to direct you in your professional duties?

DR. WOOD: That frequently happens, where a man is on a salary.

MR. HYAT: He is directed in his professional duties?

DR. WOOD: Yes.

MR. HAYT: In what way?

DR. WOOD: By choice of methods having to do with expense. Take one of our big clinics. The pathologist will want to repeat, have check-ups on the work. The patient can't be billed for those check-ups, and the management is interested solely in the total number of procedures and the money that is coming in for that. I'll cite another relationship, and it comes back to the original question: Under a salaried arrangement, the pathologist wants to give away his services. He can't do it if he is working on a salary or percentage basis; it is difficult. But if he's a free man, he can give those services away.

MR. HAYT: Let me carry through with this master and servant relationship so we will clarify the term as we use it. Is it your contention that wherever the specialist is employed on a salary, the hospital dictates to him as to the number of examinations to make for any particular patient?

DR. WOOD: I think there is a danger of that.

MR. CUNNINGHAM: Because of the salary?

DR. WOOD: Not the salary or the amount of the salary. Because he is an employe. I have seen this happen too: A pathologist has gone to some of his medical colleagues on the board and has been called down before the superintendent, who has said, "What right did you have to go to the board? You are an employe of this hospital. You come and get permission from me."

MR. HAYT: We are interested in finding out whether the fact that a man is on a salary interferes in his professional relationship with the patient, or whether he has a better professional relationship if he has a concession or is on commission, or on a rental basis. Would you say that generally where the doctor is on a salary the hospital dictates the number of examinations, the tests to be made? Would you say that is the practice? Or would you say there is only a possibility of that?

DR. WOOD: Yes, that plus the fact

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that he has no control over the number of the technicians he has, or the quality of the technicians.

DR. LITTAUER: Would you say that if he ran his own department under a rental basis that the hospital and the medical staff of the hospital would be ensured that he would have an adequate number of technicians?

DR. WOOD: There would be a much better probability.

DR. CHAMBERLAIN: We will have to admit they wouldn't be ensured, but my point is, along with such a concession must go two things: First, the fee structure has got to be approved. It should be initiated or recommended by the radiologist or laboratory physician, but it should be approved by the medical staff of the hospital.

DR. WOOD: That's right.

DR. CHAMBERLAIN: And secondly, the man in that position must not have permanent tenure. It must be possible for the hospital to kick him out, not for the purpose of bringing in somebody who will be cheaper, but for the purpose of getting someone who is more competent. I honestly believe this to be a fact, that in the hospital where the administration hires the radiologist and hires the technicians and makes all those arrangements and furnishes the facilities and pays the bills, and then decides what the radiologist shall have out of the income that comes from patients, in those hospitals the tendency is for the amount of money available for technician hire to be inadequate, the amount for secretarial hire to be inadequate, the amount available for radiologist assistants hired to be inadequate, and the only places I know where there is an absolutely adequate staff are places where the control of the department is in the hands of the head of the department, the radiologist.

MR. CUNNINGHAM: Is the explanation of that, in your opinion, a difference between hospital and medical morality?

DR. CHAMBERLAIN: No, not a bit. It is a difference in the pressure. In the old days at Stanford I could go and bring the superintendent to my department and say, "Can't you see what a mess this is?" If it was a very obvious pressure, he would say, "All right, you can have another technician," or "you can have an additional room."

MR. CUNNINGHAM: Then the solution can be found in two ways. One is through a revision of this fiscal arrangement, and the other is through simple enlightenment.

DR. CHAMBERLAIN: All right.

MR. CUNNINGHAM: You think we are going to get there faster one way and others think we will get there faster the other way?

DR. CHAMBERLAIN: I know we will get there faster where the radiologist is really the head of the department. I would like to see the radiologist autonomous in his department in the same way that the hospital administrator is autonomous in regard to the handling of general hospital problems.

MR. CUNNINGHAM: I think everybody will agree that the radiologist, the pathologist and the anesthesiologist, like every other physician, should be autonomous professionally. The disputed area is the area of professional-business operations.

DR. CHAMBERLAIN: That's right.

MR. CUNNINGHAM: It is disputed because the hospital has a responsibility in that area, too. So enlightenment is the only possible solution, isn't it?

DR. CHAMBERLAIN: Yes, I guess so.

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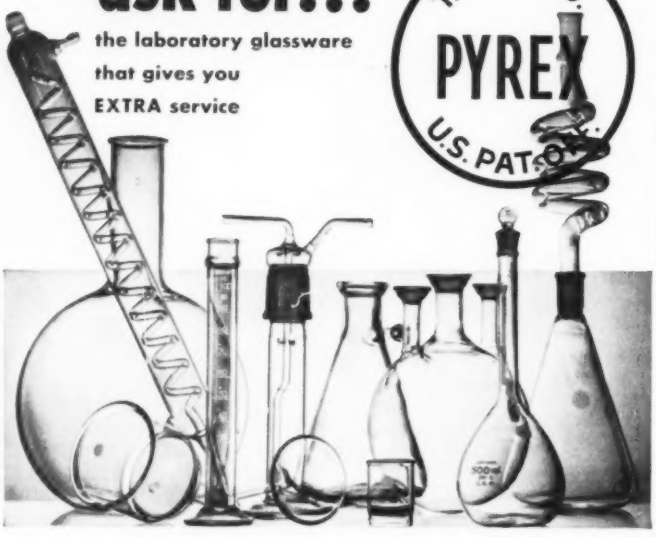

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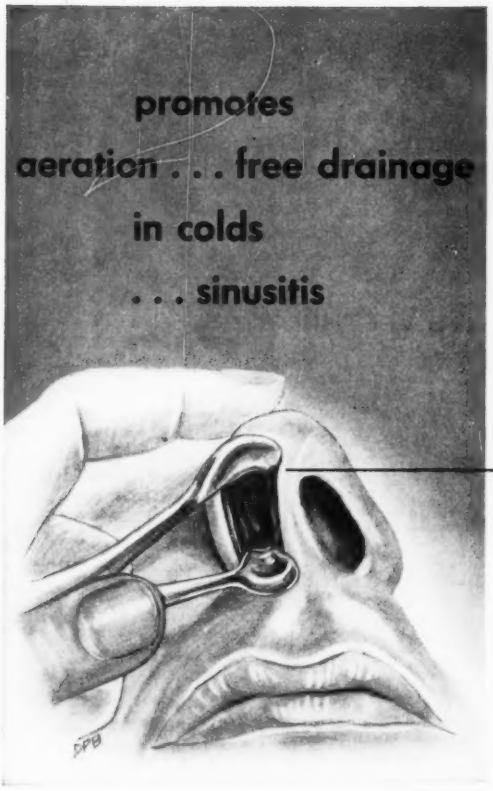

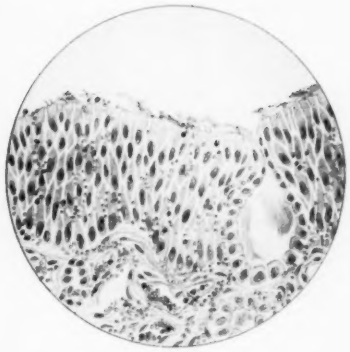

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Civic Advisory Board

(*Continued From Page 82.*)

that they are strictly "advisory," and that it is by no means imperative that their advice be followed. Board members must realize that the civic advisory board does not in any respect correspond to the official trustee body which governs the functions of the average public hospital.

Proper organization is necessary before a civic advisory board can function effectively. The board is to be purely *advisory* and *morally helpful*. Every aspect of its activities is known and governed by the personal contact of the superintendent or administrator. Every anticipated action or move should be clearly planned far ahead of concrete action. If this is done with discretion and the proper procedure is employed at each step, it will be quite possible to foresee the results. In other words, the administrator judges, directs and controls all activities through the members themselves. It is the administrator who keeps the activities of the civic advisory board within bounds.

My own experience in working with a civic advisory board of forty members has been pleasant, practical and profitable. Occasionally I have found it necessary to limit confidential business matters to a few special board members. Circumstances and the very nature of specific problems would render it injudicious to permit preliminary discussion by the entire civic advisory board. Elsewhere, I have indicated that this limited group may consist of officials of the governing board. But that is not necessary either. You may select and designate this special board group as you wish. You might adopt some such title for it as "steering" or "resolutions" committee. This select minority can be a big help when you need special counsel, some specific help or some particular information.

The advantages of a civic advisory board outnumber the disadvantages in such a ratio that the latter seem of minor importance. Tact, prudence and foresight can practically eliminate any possible negative aspects which the creation of a civic advisory board may present at first sight. Even in the most carefully selected membership of such an organization, it is quite possible to find a man who resents the fact that his counsel is neither accepted nor followed in a particular instance. You will rarely find such a person to be either a man of deep knowledge or a representative of a large concern or corporation. In a case like this, it is presupposed that the administrator has the skill and ability to mingle courtesy and caution so that it is possible to maintain harmony without taking any false steps.

It is of course vital that your board membership be confined to those who are intelligent, sincere, loyal, cooperative and unselfishly interested. The "steering" or "resolutions" committee may be able to assist you in maintaining such a board membership. Resolve personally, and have a mutual understanding with all concerned,

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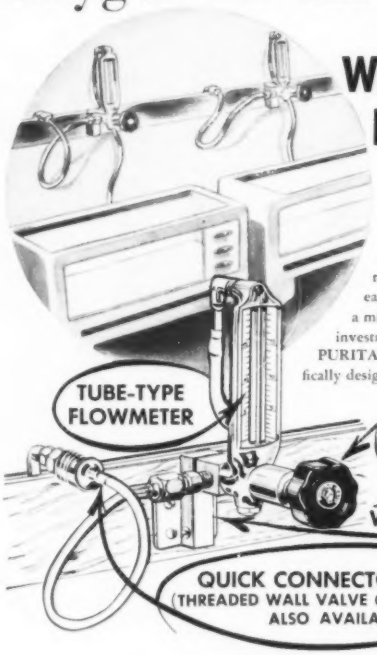

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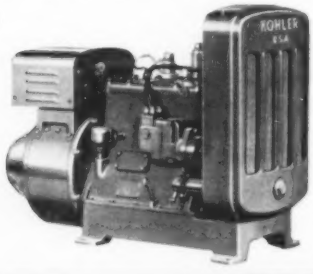

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that the civic advisory board is created to "advise." It can and should assist management, but it may not manage.

One of the outstanding services rendered to the hospital by the civic advisory board is the assistance which it gives in financial campaigns. It lends a certain dignity and prestige to the members if one of them is occasionally chosen as the chairman for an important hospital function. Perhaps a board member may officiate at the nurses' capping exercises. Another may be chosen for a more public occasion, such as a speaker for the nurses' graduation. At Christmas, the civic advisory board may officiate and function as the official Santa Claus—in either the entire hospital or any particular section of it. Civic advisory members should always be vitally interested in all civic activities relative to the hospital. The hospital should have a representative at the city planning commission. It is necessary and logical that there be membership representation in the health and welfare organization, at the safety council meetings, at chamber of commerce discussions, and also at the merchants and manufacturers association meetings.

Many of these meetings are held at night when Sisters could not attend. Lay leadership and representation at such civic meetings will probably be as effective for the benefit of your hospital. There should then be an opportunity for all the hospital civic advisory board members to become acquainted with any proceedings which have occurred relative to the hospital.

It will be recalled that in the beginning of this paper I emphasized the value of the civic advisory board as a useful two-way channel between the hospital and the public. That particular aspect of the board is most pertinent here. When board members attend these civic meetings they should have sufficient knowledge and a certain amount of delegated authority to represent the needs and general problems of the hospital. On returning to the hospital they should tell the administrator and board just how much information they released; what the public thought of the matter, and, insofar as they could ascertain, just what the people of the community would be willing to do in order to help the hospital in a given situation.

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NEWS DIGEST

Veterans Administration Reduces Building Program . . . Senators Preparing Comprehensive Health Bill . . . Legion Opposes Hoover Commission Report . . . Blue Cross Incorporates in Illinois . . . Red Cross to Extend Aide Training

Veterans Administration Reduces Building Program in Answer to President's Request

WASHINGTON, D.C.—The Veterans Administration has canceled plans to construct twenty-four new hospitals and has reduced the size of fourteen other hospitals in its building program in response to President Truman's request for reduction of the over-all program, Carl R. Gray Jr., Veterans Administrator, announced here last month. The reduction eliminates a total of 16,000 beds, the announcement said. Hospitals which will still be constructed under the reduced program total 37,000 beds, it was explained.

"Study has shown that estimated needs for hospital beds made during and immediately after the war were considerably larger than actually has proved necessary," the Veterans Administration statement declared. The change in plans was made after "a careful restudy of the V.A. hospital program," Mr. Gray stated.

Admission policies governing care of veterans with nonservice-connected disability will not be changed in the reduced program, it was emphasized. "There are no changes contemplated in the present liberal policy of hospitalization," Mr. Gray said.

Reasons given for cancellation of the proposed construction included inability to staff present hospitals and indications of continued shortages of professional personnel and continued serviceability of temporary hospitals taken over from the armed forces at the end of the war and not originally planned for continued operation.

At the present time, Veterans Administration hospitals include 110,500 beds but owing to lack of professional personnel only 103,500 beds are in actual use. Occupancy was estimated at 93,000 patients last month.

"In the light of more than three years' experience since the end of the war, it is evident that the estimates of bed requirements were considerably too high," Mr. Gray concluded.

"To construct new hospitals which we cannot staff and therefore cannot put into use would be an indefensible waste of public monies."

Projects which will be eliminated or reduced in size were listed as follows:

CANCELED

Location	*Beds*
New York	1000
Harrisburg, Pa.	200
Charlotte, N. C.	500
Salisbury, N. C.	921
Americus, Ga.	250
Chattanooga, Tenn.	500
Gainesville, Fla.	1000
Greenville, S. C.	200
Memphis, Tenn.	1000
Tallahassee, Fla.	100
Thomasville, Ga.	100
Grand Rapids, Mich.	200
Toledo, Ohio	1000
Decatur, Ill.	250
Duluth, Minn.	200
Norman, Okla.	750
El Paso, Tex.	500
Houston, Tex.	1000
Mound Bayou, Miss.	200
Tupelo, Miss.	200
Klamath Falls, Ore.	200
San Diego, Calif.	200
Columbia, S. C.	200
Detroit	500

REDUCED

Location	*Beds From*	*To*
Syracuse, N. Y.	1000	500
Philadelphia	1000	500
Pittsburgh	1200	750
Pittsburgh	1250	1000
Washington, D. C.	750	500
Atlanta, Ga.	750	500
Cincinnati	750	500
Cleveland	1000	500
Cleveland	1250	1000
Louisville, Ky.	750	500
Chicago	1000	500
Kansas City, Mo.	745	500
Oklahoma City, Okla.	1000	500
St. Louis	1000	500

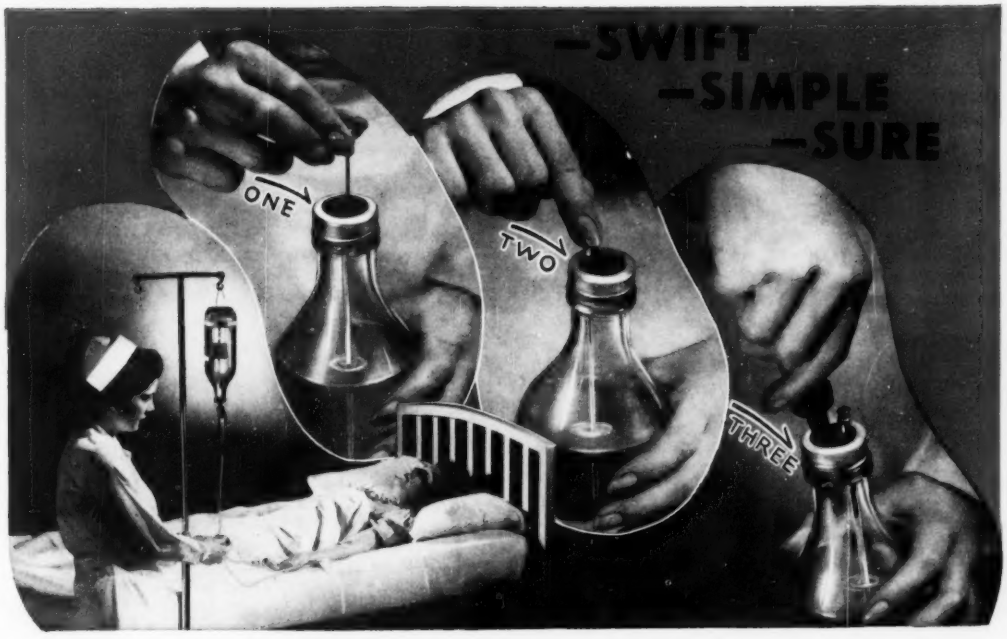
Democratic Senators Prepare Comprehensive Health Bill

WASHINGTON, D.C.—Increased federal aid for hospital construction is a major proposal in an omnibus health bill now being prepared by Democratic Senators Pepper (Fla.), Murray (Mont.) and Humphrey (Minn.), Senator Pepper told newspaper reporters following a conference with Federal Security Administrator Oscar R. Ewing here last month. Other provisions in the legislation aimed at backing up President Truman's national health program are: a federal medical research program, aid for medical and nursing students and educational institutions, nurse recruitment, and expansion of the Public Health Service, Senator Pepper said.

Some observers here said following publication of Senator Pepper's statement that the provisions for hospital construction, medical research and aid to medical and nursing education were planned by the administration to make the controversial health insurance features of the President's program more acceptable to opposition groups.

Schedule of A.C.S. Meetings

CHICAGO.—The third in a series of seven sectional meetings of the American College of Surgeons will be held in Kansas City February 11 and 12, according to an announcement by Dr. Irvin Abell, chairman of the board of regents. Illinois, Iowa, Nebraska, Kansas, Oklahoma, Arkansas and Missouri will be the main participating states although there is no geographic restriction on attendance, the announcement said. Later meetings will be held in Washington, D.C., March 15 and 16; Buffalo, N.Y., March 21 and 22; Butte, Mont., April 5 and 6, and Edmonton, Alta., April 12 and 13. Conferences for hospital personnel will be held at all the sessions, Dr. Abell said.



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NEWS...

Cooperation of Voluntary Groups Urged to Forestall Compulsory Health Insurance

NEW YORK.—Increased cooperation among government, industry, labor and the health professions to provide better distribution of hospital and medical care under the present voluntary system, instead of experimentation with compulsory health insurance measures, was urged here last month by Louis H. Pink, New York Blue Cross president, and Dr. William B. Rawls, president of the New York County Medical Society, before 600 medical and hospital leaders attending the twenty-fifth anniversary dinner of Manhattan General Hospital.

"The federal government is rightly concerned with the health of the people and is charged with the duty of seeing that the best medical care is obtained by all," Mr. Pink stated. "But that does not necessarily point to vast, centralized administrative control which may retard incentive in medical progress and lessen the responsibility of individuals and communities for personal and cooperative efforts for health and well-being."

Too much emphasis is being placed on the word "compulsory" and too little on how we can get the best, most modern and effective medical and hospital care, Mr. Pink declared. He listed an eight point program demanding government attention, as follows:

1. Extension of social security benefits to those not now protected.
2. Better housing and slum clearance.
3. Strengthening the work of the Public Health Service in preventive medicine and education.
4. Providing more modern hospitals everywhere and the means of maintaining them at a high standard, and particularly new health centers and hospitals in those areas where they are critically deficient.
5. Providing doctors in backward areas by a sound system of scholarship or grants-in-aid.
6. Financing diagnostic centers where needed.
7. Supporting medical education so that we may have more and better trained doctors, nurses and technicians of all kinds.
8. Improving and extending veterans' care and mental and tuberculosis institutions.

"No system of distribution can work with satisfaction to anyone unless this groundwork of adequate facilities is first provided," Mr. Pink concluded.

Describing the results of compulsory health insurance in other nations, Dr. Rawls said, "Much has been said about the improved medical care that compulsory health insurance will give the nation. In fourteen years of study of the economics of medicine I have never been able to find any evidence that compulsory health insurance has improved medical care, but I have found plenty of evidence that medical care has deteriorated under such a program." He stated that in all cases compulsory health insurance has brought about "a steady decline in hospital facilities, medical education, scientific research and generally a progressively lower standard of medical care."

Eighty Per Cent of Ford Employes Are Enrolled in Blue Cross-Blue Shield Plans

DETROIT.—Eighty per cent of Ford Motor Company employes throughout the United States are enrolled in Blue Cross and Blue Shield plans for hospital-surgical protection, it was announced here last month by William S. McNary, executive vice president of Michigan Hospital Service (Blue Cross). A total of 215,000 men, women and children was protected by Blue Cross through the Ford group in Michigan alone, Mr. McNary said.

At the same time, 25,115 Ford employes in other states were enrolled in Blue Cross, making a total of 62,000 Blue Cross members protected through the Ford Motor Company group outside Michigan. Thirty-five Blue Cross plans in the various states will administer the program of hospital-surgical protection for Ford workers, it was explained.

"At the request of the Ford management and union, employes were allowed to subscribe to either the hospital or the surgical service," Mr. McNary said. "We were interested to note that out of the 86,092 applications received by Michigan Blue Cross, only 253 persons chose to subscribe to the hospital plan only, and just eighty-five persons elected the surgical plan only."

Veterans' Groups Oppose Hoover Commission Report

WASHINGTON, D.C.—Following publication of the Hoover commission's medical service report recommending reorganization of federal medical services into an integrated national health bureau, the American Legion and other veterans' organizations here declared vigorous opposition to "any action that will spell the disintegration or absorption of the Veterans Administration."

Speaking for the American Legion, T. O. Kraabel, national rehabilitation director, said the group would oppose any "dilution or devitalizing of the present program of the best possible medical and hospital care for veterans." Mr. Kraabel recalled the Legion's "long hard fight for an independent federal agency to handle veterans' affairs.

"The Legion holds that medical and hospital services of the best quality are essential not only to adequate identification and treatment of diseases but also as to exhaustive and correct descriptions for purposes of adjudicating veterans' claims," said Mr. Kraabel.

Dissatisfaction with the commission's recommendations regarding Veterans Administration hospital and medical care programs was also expressed by representatives of the Disabled American Veterans, Jewish War Veterans, Veterans of Foreign Wars and Amvets.

Blue Cross Association Incorporates in Illinois

CHICAGO.—The Blue Cross commission announced last month that the Blue Cross association had been incorporated as an Illinois not-for-profit corporation. The new corporation was described as the first step toward realization of the nationwide voluntary prepayment program initially proposed for cooperative operation by the Blue Cross and Blue Shield commissions.

The association will raise capital funds with which to organize an operating agency to be known as the Blue Cross Health Service, Inc., it was explained. The health service will be a stock insurance company.

Incorporators of the association were Dr. Paul R. Hawley, chief executive officer of the Blue Cross and Blue Shield commissions, Richard M. Jones, director, and Antone G. Singsen, assistant director.

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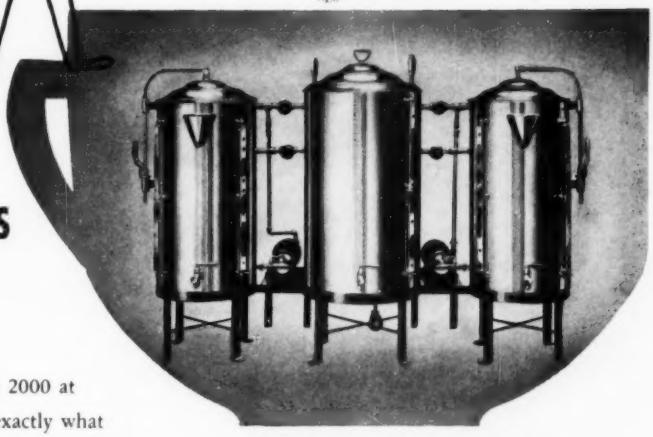

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NEWS...

Red Cross Will Extend Training Course for Volunteer Nurse's Aides

WASHINGTON, D.C.—The American Red Cross is planning to extend its program of training volunteer nurse's aides, it was announced at national headquarters here last month.

With the cooperation of the Boston chapter, the headquarters staff has undertaken a study of a revised course for nurse's aides, which not only will train aides for service in hospitals, as in the past, but will also provide training for service in public health agencies, the announcement said. The new course is designed to meet the increasing need for care of the aged, extension of service to assist with care of patients after they leave hospitals, care of the chronically ill, and other aspects of nursing care outside as well as within hospitals, it was explained.

Under the new plan, nurse's aides will be trained for service in hospitals or with public health agencies, depending on community needs. As a result of this study, a new manual will be prepared and Red Cross chapters will have an opportunity to present the course in their communities.

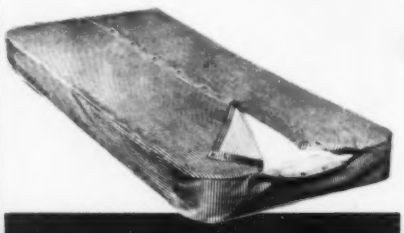
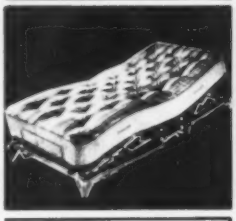
Another extension of the volunteer nurse's aide service will result from a recently developed cooperative plan with the Veterans Administration. Under this arrangement, veterans' hospitals may provide hospital facilities for on-the-job instruction of student nurse's aides following the preliminary training course. The Red Cross will provide an instructor for the entire course, who will supervise the aides during their practice in the veterans' hospital.

Reactivation of the nurse's aide program has the support of the American Hospital Association, it was reported. The development of new plans to help meet present demands for such trained assistance to nurses has resulted in an increasing need for more nurses to volunteer as instructors for training nurse's aides, it was pointed out. "The Red Cross offers qualified nurses an opportunity to make a further contribution to their communities by serving as instructors for this program; nurses who are interested in serving in this capacity are urged to notify their local Red Cross chapter," the headquarters announcement stated.

Army Will Select Medics for Civilian Training Programs

WASHINGTON, D.C.—Approximately 300 practicing physicians and an additional 300 medical school graduates will be selected for participation in the civilian residency and intern training programs established by the army medical department, it was announced in the office of the surgeon general here last month.

Under the program, it was explained, physicians and medical school graduates obtaining acceptable resident and internship appointments may apply for regular army commissions and participate in the program if they are selected by the surgeon general on review of their qualifications. Commissions will be in the grades of first lieutenant and captain, it was explained. Those selected will be required to serve two years of active duty for each year of formal training received under army medical department auspices, the announcement said.

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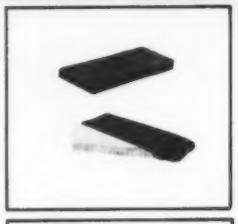

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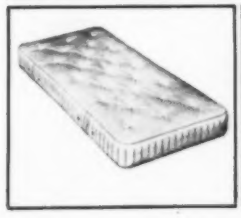

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NEWS...

More Than 52,000,000 Covered by Hospital Insurance, Survey Shows

NEW YORK.—More than 52,000,000 people are now protected under some form of voluntary hospitalization insurance, while voluntary surgical and medical expense insurance plans cover approximately 26,000,000 and 9,000,000, respectively, according to a survey made by a number of trade associations of insurance companies. A report of the survey was released here last month by the Life Insurance Association of America. Based on a nationwide analysis, the findings are thought to represent the first comprehensive survey of such plans covering insurance companies, Blue Cross, and all other types of organizations providing this protection, the report said.

"The figures demonstrate how extensively the American people have undertaken the job of establishing their own protection through private channels against the costs of sickness and accident," an association official said. "The growth of these plans has been accelerated since the end of the war, giving promise that much more nearly complete protection for the population will be secured on a voluntary basis in the future. The extent of voluntary coverage and the rapid rate of growth show that private enterprise is well able to meet the public need for this essential protection although, admittedly, much more remains to be accomplished. Existing coverage extends to all income levels of those regularly employed, often with employer financial support."

The carriers insuring these people against hospitalization expense at the time the survey was made were as follows: insurance companies and fraternal societies, with an aggregate of nearly 21,000,000 covered; Blue Cross plans and plans sponsored by medical societies, with 28,000,000; plans in the bituminous coal and other industries, private group clinics, university health plans and consumer sponsored groups, with an aggregate of more than 3,000,000.

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Omaha Completes Survey of Hospital Facilities

OMAHA, NEB.—A detailed survey of hospital facilities, equipment and inventories in the Omaha area has been completed by a special committee of the Omaha Area Hospital Council, it was announced here last month. The survey was aimed at showing how hospital and medical resources of the area could best be organized in case of a major disaster, it was reported.

Hal Perrin, superintendent of the Clarkson Memorial Hospital, was chairman of the survey committee which will continue its studies so that current information on available services will always be on hand.

Plan Medical Buildings

GALVESTON, TEX.—Plans for new University of Texas medical branch buildings costing more than $6,000,000 are being considered by a faculty building committee, the university announced here last month. The proposed new buildings include a general hospital and private pavilion to be erected by the Sealy and Smith Foundation at an estimated cost of $3,500,000. Additional hospital facilities also include a thirty-two-bed Henry and Rose Zeigler tuberculosis hospital.

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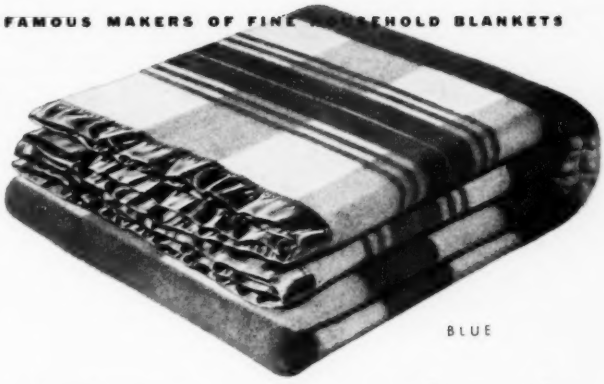

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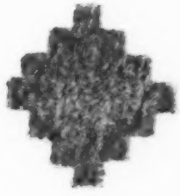
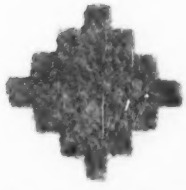


GREEN



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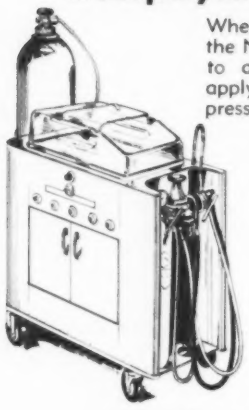

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NEWS...

COMING MEETINGS

AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS, Cleveland, Sept. 25-26.

AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS, Educational Conference, Netherland Plaza Hotel, Cincinnati, Feb. 21-25.

AMERICAN COLLEGE OF SURGEONS, Sectional Meetings: Hotel President, Kansas City, Mo., Feb. 11-12; Statler Hotel, Washington, D. C., March 15-16; Statler Hotel, Buffalo, N.Y., March 21-22; MacDonald Hotel, Edmonton, Alta., April 12-13.

AMERICAN CONGRESS OF OBSTETRICS AND GYNECOLOGY, Hotel Statler, New York City, May 14-19.

AMERICAN HOSPITAL ASSOCIATION, Cleveland, Sept. 26-29.

AMERICAN HOSPITAL ASSOCIATION, Mid-Year Conference of Presidents and Secretaries, Drake Hotel, Chicago, Feb. 4-5.

AMERICAN OCCUPATIONAL THERAPY ASSOCIATION, Book-Cadillac Hotel, Detroit, Aug. 23-25. Institute, Aug. 26, 27.

AMERICAN PROTESTANT HOSPITAL ASSOCIATION, Cleveland, Sept. 23-24.

AMERICAN SOCIETY OF MEDICAL TECHNOLOGISTS, Hotel Roanoke, Roanoke, Va., June 20-23.

AMERICAN SOCIETY OF X-RAY TECHNICIANS, San Francisco, June 5-10.

ARIZONA HOSPITAL ASSOCIATION, Phoenix, Feb. 11-12.

ARKANSAS HOSPITAL ASSOCIATION, Marion Hotel, Little Rock, May 16-17.

ASSOCIATION FOR PHYSICAL AND MENTAL REHABILITATION, Hotel New Yorker, New York City, May 18-21.

ASSOCIATION OF WESTERN HOSPITALS, Civic Auditorium, San Francisco, May 9-12.

CAROLINAS-VIRGINIAS HOSPITAL ASSOCIATION, Asheville, N. C., April 21-22.

CATHOLIC HOSPITAL ASSOCIATION, St. Louis, June 13-16.

IOWA HOSPITAL ASSOCIATION, Fort Des Moines Hotel, Fort Des Moines, April 22.

KENTUCKY HOSPITAL ASSOCIATION, Kentucky Hotel, Louisville, March 20-April 1.

MARYLAND-DISTRICT OF COLUMBIA-DELAWARE HOSPITAL ASSOCIATION, duPont Hotel, Wilmington, Del., Nov. 14-15.

MASSACHUSETTS HOSPITAL ASSOCIATION, Statler Hotel, Boston, March 28.

MIDDLE ATLANTIC HOSPITAL ASSEMBLY, Convention Hall, Atlantic City, N. J., May 18-20.

MID-WEST HOSPITAL ASSOCIATION, Kansas City, April 26-28.

NATIONAL ASSOCIATION OF METHODIST HOSPITALS AND HOMES, Congress Hotel, Chicago, Feb. 16-17.

NEW ENGLAND HOSPITAL ASSEMBLY, Hotel Statler, Boston, March 28-30.

OHIO HOSPITAL ASSOCIATION, Nell House, Columbus, Ohio, March 23-26.

SOUTHEASTERN HOSPITAL CONFERENCE, Buena Vista Hotel, Biloxi, Miss., April 27-29.

TENNESSEE HOSPITAL ASSOCIATION, Andrew Jackson Hotel, Nashville, March 17-19.

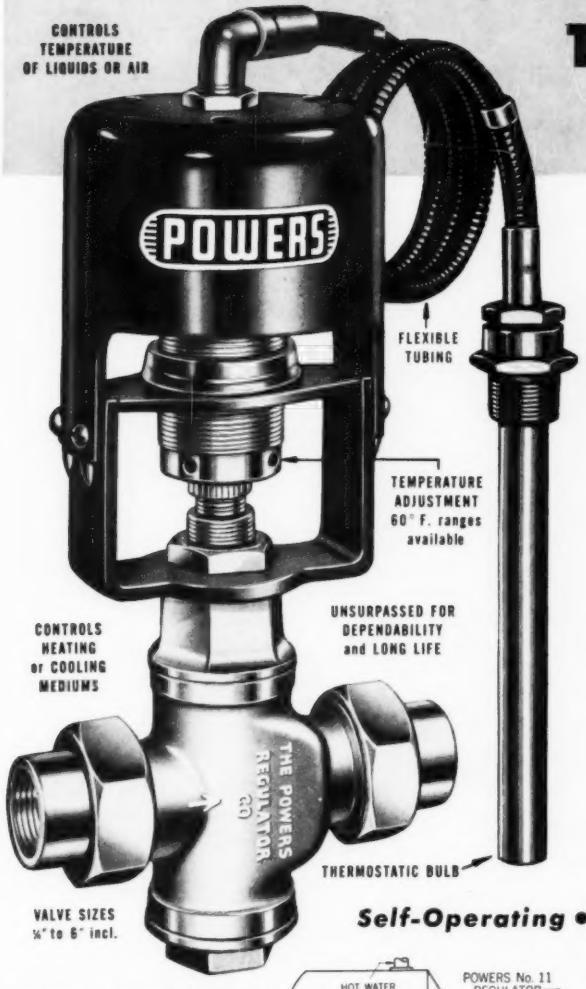
TEXAS HOSPITAL ASSOCIATION, Buccaneer Hotel, Galveston, April 19-21.

TRI-STATE HOSPITAL ASSEMBLY, Palmer House, Chicago, May 2-4.

UPPER MIDWEST HOSPITAL CONFERENCE, Minneapolis, May 26-28.

WISCONSIN HOSPITAL ASSOCIATION, Schroeder Hotel, Milwaukee, Feb. 17.

When You Want LOW COST TEMPERATURE CONTROL



for

- WATER HEATERS
- FUEL OIL HEATERS
- HOT WATER LINE CONTROL
- DRINKING WATER COOLING
- DISH WASHERS
- STEAM TABLES • COFFEE URNS
- COOKING KETTLES
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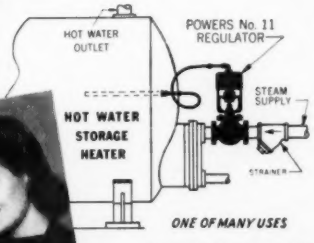
Use POWERS No. 11 REGULATORS

Self-Operating • Easy To Install • Economical

Regulator can be supplied with Dial Thermometer—a feature pioneered by POWERS back in 1930.



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SIMPLIFY your temperature control problems with Powers No. 11 Regulators. They prevent over-heating—save steam and labor—often give 10 to 25 years of dependable control and pay back their cost several times a year. Just the regulator for many applications requiring a constant temperature.

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1183

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OFFICES IN 50 CITIES • SEE YOUR PHONE BOOK

Over 55 Years of Temperature and Humidity Control

NOW...MODERNIZE YOUR Rx DEPARTMENT AT NO EXTRA COST

Do it with the New Merck Fused-Label Chemical Bottles

RAHWAY, N. J.—Merck & Co., Inc. has begun distribution of the new Merck *fused-label* chemical bottle sets. Pharmacists who have examined these uniquely modern, permanent containers state that they are ideal in many ways.

These new containers give greater legibility to labels. The labels take plenty of wear without becoming soiled or nicked. Any soilage is easily removed with a cloth or a piece of paper. Bottles and labels are designed for professional appearance and workability. The "Duraglas" bottles are extremely easy to handle, and the clear legibility of the labels is a real factor in saving the pharmacist's time.

There is no extra cost involved, since you pay no premium for the *fused-label*. For your convenience, the filled Merck bottles are assorted in sets of 25 and 12, according to size. Set A includes the twenty-five most frequently used prescription chemicals, in the 250 cc. size.

Dual Label Follows New Official Nomenclature

An outstanding feature of the new Merck *fused-label* bottles is the second or "working" label on the side opposite to the name label. While the display label carries the English title in bold type, working labels give name, weight and other pertinent data. Both labels on each bottle are part of the glass itself.

PUNISHMENT TESTS PROVE WEARABILITY ON THE JOB

In the development of this new prescription chemical bottle, the labels were subjected to extensive "wear-and-tear" tests. They withstood, without damage, any commercial treatment that glass itself will stand. The labels cannot be marred by scratch marks in ordinary usage. They can be disfigured only by treatment that is capable of marring glass, and by concentrated acids or lye.

GLASSMAKER REVEALS PROCESS

Label Fused to Bottle at 1,100° Temperature

MILLVILLE, N. J.—Unlike old-time labels, the new Merck chemical bottle label is *fired into the glass and is part of the glass itself*. In explaining the process, glass engineers report that pigments are fused at a temperature of 1,100°. This modern procedure assures permanency and legibility; the moistureproof label can be cleaned easily with a wet cloth or dry cloth.

Dual Label Improves Professional Store Appearance

SAN FRANCISCO, CALIF.—Test-store experience with the new Merck bottles has shown how the working set can serve as a good-looking professional display. With working labels facing the prescription laboratory, a modern, uniform row of display labels is seen by the customer.

Department Modernizing Made Easy

CHICAGO, ILL.—Midwest pharmacists who have inspected the new Merck *fused-label* prescription chemical containers are delighted with the possibilities they offer in modernizing their prescription departments and in facilitating prescription procedure. These pharmacists call attention to the following advantages of the new bottles:

1 **Neat, professional appearance.**
2 **Practical, hand-grasp shape and legible lettering.**
3 **Labels that will last as long as the bottles.**
4 **Convenience in ordering by pre-arranged sets.**
5 **Availability of the new *fused-labels* without extra cost.**

HOW TO ORDER

Get Set "A" Now... Other Sets Later

1. The New Merck *fused-label* bottles will be supplied in two sizes—250 cc., and 750 cc.

2. You pay no premium for the new *fused-label*.

3. The bottles are filled and can be ordered only in sets as listed at right.

4. Sets have been grouped according to frequency of use.

5. Bottles are not available singly or empty, except as replacements in case of breakage or loss, or in the event of chemical shortages.

6. Orders will be accepted now for any one or all sets.

7. Sets may be ordered for direct shipment by Merck & Co., Inc., from Rahway, N. J., St. Louis, Mo., or Los Angeles, Calif., with invoicing through your wholesaler. Or place your order with your Merck or wholesaler's representative.

MERCK

CHEMICAL LIST—PRESCRIPTION SET

Each set in Schedule I consists of 25 chemicals in 250 cc. bottles
Each set in Schedule II consists of 12 chemicals in 750 cc. bottles

(Offer subject to price change and prior sale)

SCHEDULE I—250 cc. BOTTLES

SET A—$12.62

Acetophenetidin U.S.P. Powd.	4 oz.
Acid Acetylsalicylic U.S.P. Powd.	4 oz.
Acid Boric U.S.P. Powd.	4 oz.
Ammonium Chloride U.S.P. Gran.	7 oz.
Bismuth Subnitrate N.F.	4 oz.
Calcium Carbonate Precip. U.S.P.	3 oz.
Calc. Phos. Tribasic N.F. Precip.	2 oz.
Chloral Hydrate U.S.P. Loose Cryst.	8 oz.
Dextrose U.S.P.	5 oz.
Ephedrine Hydrochloride U.S.P.	1 oz.
Magnesium Oxide Heavy U.S.P.	3 oz.
Milk Sugar U.S.P. Powd.	4 oz.
Potassium Citrate U.S.P. Gran.	10 oz.
Potassium Iodide U.S.P. Gran.	15 oz.
Potassium Permanganate U.S.P. Gran.	12 oz.
Sodium Bicarbonate U.S.P. Powd.	8 oz.
Sodium Bromide U.S.P. Gran.	16 oz.
Sodium Chloride U.S.P. Gran.	10 oz.
Sodium Citrate U.S.P.	10 oz.
Sodium Salicylate U.S.P. Cryst. Free-Flowing	6 oz.
Sodium Sulfate U.S.P. Gran.	8 oz.
Sulfanilamide U.S.P. Not Steril.	4 oz.
Talc. U.S.P.	4 oz.
Zinc Oxide U.S.P.	4 oz.
Zinc Sulfate U.S.P. Gran.	8 oz.

SET B—$10.77

Acid Citric U.S.P. Gran.	7 oz.
Acid Salicylic U.S.P. Fine Cryst.	2 oz.
Acid Tannic U.S.P. Fluffy	1 oz.
Acid Tartaric U.S.P. Powd.	6 oz.
Ammonium Carbonate U.S.P. Chips	4 oz.
Bismuth Subcarbonate U.S.P.	4 oz.
Calamine Prep. U.S.P.	4 oz.
Calcium Gluconate U.S.P. Powd.	2 oz.
Calcium Lactate U.S.P. Powd.	4 oz.
Calcium Phosphate Dibasic U.S.P.	6 oz.
Choline Chloride	4 oz.
Kaolin Colloidal N.F.	4 oz.
Lead Acetate U.S.P. Gran.	8 oz.
Magnesium Carbonate U.S.P. Powd.	1 oz.
Magnesium Carbonate U.S.P. Heavy Powd.	3 oz.
Magnesium Oxide U.S.P. Light Powd.	1 oz.
Magnesium Trisilicate U.S.P.	3 oz.
Potassium Bromide U.S.P. Gran.	12 oz.
Quinine Sulfate U.S.P.	1 oz.
Saccharin Sodium U.S.P. Powd.	4 oz.
Sodium Benzoate U.S.P. Powd.	3 oz.
Sodium Thiosulfate U.S.P. Cryst.	8 oz.
Strontium Bromide N.F. Cryst.	8 oz.
Sulfathiazole U.S.P. Not Steril	4 oz.
Sulfur U.S.P. Precip.	3 oz.

SET C—$16.22

Acetanilid U.S.P. Powd.	3 oz.
Acid Benzoic U.S.P. Cryst.	2 oz.
Aluminum Chloride N.F.	6 oz.
Aminopyrine U.S.P. Powd.	1 oz.
Ammonium Bromide N.F. Gran.	10 oz.
Bismuth Subgallate N.F.	4 oz.
Caffeine Citrated U.S.P.	1 oz.
Calcium Bromide N.F.	4 oz.
Calomel U.S.P.	1 oz.
Ephedrine Sulfate U.S.P. Cryst.	1 oz.
Hexamethylenamine U.S.P. No. 30 Mesh	8 oz.
Phenobarbital U.S.P.	1 oz.
Phenobarbital Sodium U.S.P. Gran.	1 oz.
Potassa Sulfurated N.F.	4 oz.
Potassium Acetate U.S.P.	8 oz.
Potassium Chlorate N.F. Gran.	12 oz.
Potassium Guaiacol Sulfonate N.F.	6 oz.
Quinine Bisulfate U.S.P. Cryst.	1 oz.
Quinine Hydrochloride U.S.P.	1 oz.
Resorcin U.S.P. Recrystallized	2 oz.
Salol N.F. Gran.	4 oz.
Silver Nitrate C.P. Cryst.	1 oz.
Sulfathiazole Sodium U.S.P. Not Steril.	6 oz.
Theophylline Ethylenediamine U.S.P.	1 oz.
Zinc Chloride N.F. Gran.	10 oz.

SET D—$17.89

Activated Charcoal U.S.P. Powd.	1 lb.
Antipyrine N.F.	4 oz.
Benzocaine U.S.P. Fine Powd.	1 oz.
Camphor Monobromated N.F. Cryst.	1 oz.
Cerium Oxalate N.F.	7 oz.
Cinchophen N.F.	1 oz.
Copper Sulfate U.S.P. Gran.	8 oz.
Guaiacol Carbonate N.F. VII	1 oz.
Iron by Hydrogen N.F.	1 oz.
Iron Sulfate (Ferrous) U.S.P. Cryst.	8 oz.
Iron & Ammon. Citrate U.S.P. Brown Pearls	6 oz.
Mercury Ammoniated U.S.P. Powd.	1 oz.
Pepsin N.F. Powd.	1 oz.
Potassium Bicarbonate U.S.P. Gran.	8 oz.
Potassium Bitartrate N.F. Powd.	7 oz.
Potassium Chloride U.S.P. Cryst.	8 oz.
Potassium Thiocyanate N.F. Cryst.	6 oz.
Quinidine Sulfate Natural U.S.P.	1 oz.
Silver Protein Mild U.S.P.	1 oz.
Sodium Iodide U.S.P.	16 oz.
Yergin Hydrate N.F. Powd.	3 oz.
Theobromine	1 oz.
Theobromine Sodio Salicylate N.F.	4 oz.
Thymol U.S.P.	1 oz.
Thymol Iodide N.F. Powd.	2 oz.

SCHEDULE II
750 cc. Bottles

SET E—$13.39

Acetophenetidin U.S.P. Powd.	10 oz.
Acid Acetylsalicylic U.S.P. Powd.	14 oz.
Acid Boric U.S.P. Powd.	15 oz.
Calcium Carbonate Precip. U.S.P.	8 oz.
Calcium Phos. Tribasic N.F. Precip.	7 oz.
Magnesium Oxide Heavy U.S.P.	9 oz.
Milk Sugar U.S.P. Powd.	15 oz.
Potassium Citrate U.S.P. Gran.	24 oz.
Potassium Iodide U.S.P. Gran.	32 oz.
Sodium Bicarbonate U.S.P. Powd.	24 oz.
Sodium Salicylate U.S.P. Cryst. Free-Flowing	16 oz.
Zinc Oxide U.S.P.	14 oz.

SET F—$14.58

Ammonium Chloride U.S.P. Gran.	16 oz.
Bismuth Subnitrate N.F.	15 oz.
Chloral Hydrate U.S.P. Loose Cryst.	16 oz.
Dextrose U.S.P.	16 oz.
Potassium Permanganate U.S.P. Gran.	32 oz.
Sodium Bromide U.S.P. Gran.	48 oz.
Sodium Chloride U.S.P. Gran.	24 oz.
Sodium Citrate U.S.P.	24 oz.
Sodium Sulfate U.S.P. Gran.	20 oz.
Sulfanilamide U.S.P. Not Steril.	10 oz.
Talc U.S.P.	14 oz.
Zinc Sulfate U.S.P. Gran.	16 oz.

SET G—$12.37

Acid Citric U.S.P. Gran.	20 oz.
Acid Salicylic U.S.P. Fine Cryst.	4 oz.
Acid Tannic U.S.P. Fluffy	5 oz.
Acid Tartaric U.S.P. Powd.	16 oz.
Bismuth Subcarbonate U.S.P.	12 oz.
Calamine Prep. U.S.P.	15 oz.
Calcium Phosphate Dibasic U.S.P.	16 oz.
Magnesium Trisilicate U.S.P.	8 oz.
Potassium Bromide U.S.P. Gran.	32 oz.
Saccharin Sodium U.S.P. Powd.	8 oz.
Sodium Benzoate U.S.P. Powd.	8 oz.
Strontium Bromide N.F. Cryst.	24 oz.

SET H—$15.35

Ammonium Carbonate U.S.P. Chips	16 oz.
Calcium Gluconate U.S.P. Powd.	8 oz.
Calcium Lactate U.S.P. Powd.	12 oz.
Kaolin Colloidal N.F.	10 oz.
Lead Acetate U.S.P. Gran.	24 oz.
Magnesium Carbonate U.S.P. Powd.	3 oz.
Magnesium Carbonate U.S.P. Heavy Powd.	10 oz.
Magnesium Oxide U.S.P. Light Powd.	3 oz.
Quinine Sulfate U.S.P.	5 oz.
Sodium Thiosulfate U.S.P. Cryst.	24 oz.
Sulfathiazole U.S.P. Not Steril.	15 oz.
Sulfur Precip. U.S.P.	14 oz.

MERCK & CO., Inc. *Manufacturing Chemists* RAHWAY, N. J.

DEPT. M & P-29

Gentlemen:

Please reserve for me chemical sets checked below:

A ☐ | C ☐ | E ☐ | G ☐
B ☐ | D ☐ | F ☐ | H ☐

Wholesaler's name .....

Wholesaler's Salesman .....

Name or store label .....

Street .....

City .....State.....

NEWS...

Discharge Eligible Patients From State Hospitals, Gov. Stevenson Urges

SPRINGFIELD, ILL.—The discharge of a large number of patients in state mental hospitals was proposed by Governor Adlai Stevenson in his inaugural address here last month as a necessary measure aimed at relieving overcrowding in state institutions. Patients will be carefully selected for discharge and continued home care, it was indicated.

"The population of our mental hospitals is growing at an alarming rate," Governor Stevenson said in his address. "The deficiencies in their accommodations, care and treatment are well known. So is the appalling cost of new building on a scale to meet the demand. So also is the dearth of competent trained personnel to staff existing facilities properly, let alone large additional facilities.

"The population of our mental institutions, which now exceeds 40,000, can and should, I think, be reduced. Many of these patients are merely aged and infirm or senile. They do not need elaborate psychiatric and nursing care. Segregation with proper custodial facilities and care should both cost less and provide more humane care. Others could be discharged and maintained in their own or foster homes with the aid of old age pensions. Still other patients could be discharged and maintained at home, treated and cared for through local agencies under the supervision of the state."

Illinois is already using the home care idea, public welfare department officials said following the address. Approximately 700 former patients are now being cared for in homes, it was estimated. The possible maximum number eligible for such care was estimated to be 10,000.

Texas Colleges to Improve Nurse Education Program

AUSTIN, TEX.—Improvement of the bachelor of science college degree program in nursing was in prospect following a conference of the council of Texas collegiate schools of nursing at the University of Texas here last month, according to a university announcement. Educators from four of the state's institutions were present for the meeting. State nursing leaders who participated were: Irene Healy, university nursing education department, chairman; Marjorie Bartholf, dean of the University of Texas School of Nursing at Galveston; Lucy Harris, dean of Harris College of Nursing, Texas Christian University; Zora Fiedler, dean of the Baylor University School of Nursing, Dallas, and Sister Charles Marie, nursing education director, Incarnate Word College, San Antonio.

Palsy Center to Open

BOWLING GREEN, OHIO.—The first cerebral palsy center of its kind in the nation will be opened next fall at Bowling Green State University, it was announced here last month by officials of the university and the Ohio Society for Crippled Children, co-sponsors of the project. Children at the center will have the benefit of not only speech and hearing therapy but also muscular training at the hands of skilled physical and occupational therapists working under medical direction, a university announcement said.

Does Your Hospital Have "Nurse Appeal"?

The nurse shortage constitutes a grave menace to public health according to a recent report of the American Nurses' Association, which states: "The supply of nursing care will never meet the demand *until basic improvements are made in the conditions under which the nurse works today.*"

One of the major causes of nurses' complaints is the odor problem which makes their daily work so unpleasant.

Many leading hospitals solve the problem of odors and stale air with Airkem Chlorophyll Air Freshener. They use Airkem in the familiar wick-bottle to counteract odors in small rooms and they also like the easy-to-service wall cabinet. In larger areas, more and more hospitals are using the new portable Airkem Osmefans for odor-counteraction.

With Airkem you can make your whole staff more comfortable, thus more efficient. You can give your patients odor free air which may help speed recovery. You can welcome visitors to your hospital into Air of Quality.

Order Airkem wick-bottles and mechanical equipment from your local Airkem representative or write to Airkem, Inc., 241 East 44th Street, New York 17, N.Y.

Airkem

Controls Odors Originating In:

1 Odorous disease wards
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6 Lavatories
7 Freshly painted rooms
8 Laundry and chutes
9 Kitchens

PRATT & LAMBERT PAINT AND VARNISH

PSYCHIATRIC UNIT, WESTON (W. VA.) STATE HOSPITAL
L. D. SCHMIDT & SON, Architects, Fairmont, W. Va. PLATE CONSTRUCTION CO., General Contractors, Parkersburg, W. Va. H. R. HOWELL CO., Painting Contractor, Parkersburg, W. Va. Photo at left (top) shows third floor bed cubicles; (below) Occupational Therapy Department.

THIS project consisted of the designing and erection of a Psychiatric Unit for men, and the reconstruction of a similar unit for women. The new unit for men is the result of exhaustive study and consultation with some of the nation's foremost psychiatrists.

Here, under one roof, are all of the essential facilities for the rehabilitation of mental patients. It was designed to give patients a feeling of freedom, to develop good living habits, to administer the proper treatments and to provide occupational therapy.

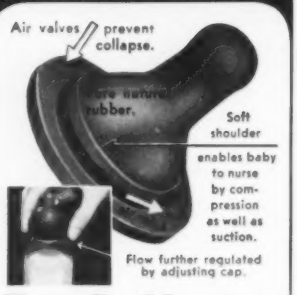
The correct use of Pratt & Lambert Paint colors here, as in many hospitals throughout the Country, contributes to the well-being of patients and staff.

Hospital authorities, desirous of using appropriate color for its obvious therapeutic benefits, at low maintenance cost, should write Pratt & Lambert-Inc., 126 Tonawanda St., Buffalo 7, N.Y. In Canada, 18 Courtwright St., Fort Erie, Ontario.

Save the surface
and
you save all!

1849 — Pratt & Lambert Centennial Year — 1949

Ideal For Premature, Normal Babies



Evenflo Nursing like Breast Feeding

Nipples that *look* like the breast are not enough. They must provide the healthful sucking that Nature intended but without the frustration caused by collapsed nipples or the fatigue that results from nursing hard, stiff nipples. Equally bad are large-holed nipples that require no sucking at all.

Natural Action

The Evenflo Nipple must be nursed. But because of Evenflo's twin air valves, normal air pressure is maintained inside the bottle. This allows the milk to come smoothly and easily. The shoulder as well as the feeding tip of the Evenflo Nipple is soft and pliable so baby can nurse by compression as well as suction.

Ideal for Hospitals

The superiority of Evenflo Nursers for home feeding has long been recognized by pediatricians. Now these nursers are available in 4-oz. size for hospitals. Their nipple, bottle, cap all-in-one makes them perfect for autoclaving. Why not try them in your own maternity ward? Write for free sample and literature.

Dept. M
THE PYRAMID RUBBER CO.
RAVENNA, OHIO

Evenflo©
America's Most Popular Nurser
Ideal Hospital Unit →

Approved by Doctors and Nurses

NEWS...

Medical, Hospital Groups Oppose Health Bill Sponsored by Warren

SACRAMENTO, CALIF.—State medical and hospital groups were making plans here last month to organize opposition to a compulsory hospitalization insurance bill sponsored by Gov. Earl Warren and introduced in the state legislature by Senator Byrl Salsman of Palo Alto. The bill would levy a 1 per cent pay roll tax on employers and an additional 1 per cent on employes to finance payment of medical and hospital bills in case of hospitalized illness.

Similar bills were introduced by Governor Warren in 1945 and 1947 and opposed by hospital and medical groups. Previous bills did not reach the floor for vote.

In a press conference, Governor Warren denied that the Salsman bill constituted socialized medicine. "It is social progress not socialism," the governor insisted. "It's no more socialism than unemployment insurance or workmen's compensation."

Governor Warren stated that he would not insist on passage of this bill so long as the legislature would agree to some provision for a state hospitalization insurance program that would provide a "reasonable start" on a health plan.

As explained by the governor, the bill would provide free choice of hospital and doctors.

Bans Hiring Unlicensed Persons for Nursing Service

ALBANY, N.Y.—Performance of nursing service for hire by unlicensed persons will become illegal in New York State effective April 1 under provisions of the Nurse Practice Act adopted here in 1938. This provision of the Act was suspended because of the wartime shortage of nurses; the suspension, which has continued since the war, will end April 1.

In an effort to assure hospital administrators that they may still employ auxiliary hospital workers after the effective date of the act, the state nurses association has issued a list of more than 100 services that can be performed by hospital employes other than nurses. Many of these duties are now performed by licensed nurses, the association has explained, and this fact is a contributing cause of the continuing nurse shortage.

WIN SMILES!
SAVE MONEY!

REAL GOLD

CALIFORNIA
Citrus Juice Bases

So Economical. Rich in vital Vitamin C, these California juice bases provide healthful, delicious drinks for your patients. And so inexpensive, too! Each 10½ oz. can of Real Gold base makes ½ gallon when properly diluted with water. Real Gold bases also come in gallon containers, which are diluted 6 to 1.

- REAL GOLD ORANGE BASE
- REAL GOLD LEMON BASE
- REAL GOLD GRAPEFRUIT BASE

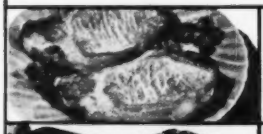
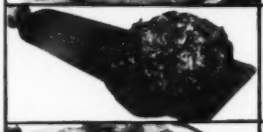
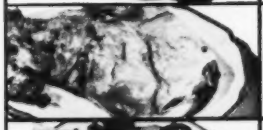
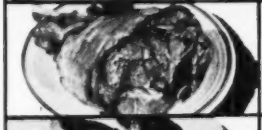
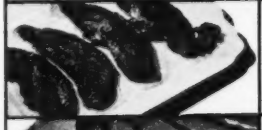
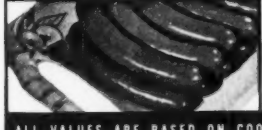
Real Gold bases are the concentrated juice of fresh oranges, lemons and grapefruit. Most of the water from the freshly reamed juice is removed by Real Gold's special low temperature, vacuum-evaporation process, which protects the precious Vitamin C. The resulting concentrate is blended with just the right amounts of sugar, dextrose and pure fruit oils to enhance fully its natural goodness and flavor. It is homogenized just before canning for lasting quality and uniformity

DOES NOT REQUIRE REFRIGERATION!

Write for samples.

SOUTHERN CALIFORNIA CITRUS FOODS
Division of Mutual Orange Distributors
Redlands, California

The Abundant Nutrient Values of MEAT

KIND OF MEAT		COMPLETE PROTEIN	B VITAMINS			FOOD IRON
			THIAMINE (B_1)	RIBOFLAVIN (B_2)	NIACIN	
	PORK	EXCELLENT	EXCELLENT	FAIR	EXCELLENT	EXCELLENT
	BEEF	EXCELLENT	FAIR	EXCELLENT	EXCELLENT	EXCELLENT
	LAMB	EXCELLENT	FAIR	GOOD	EXCELLENT	EXCELLENT
	VEAL	EXCELLENT	GOOD	GOOD	EXCELLENT	EXCELLENT
	VARIETY MEATS (LIVER, HEART, KIDNEY)	EXCELLENT	EXCELLENT	EXCELLENT	EXCELLENT	EXCELLENT
	SAUSAGE (FRANKFURTERS, BOLOGNA)	EXCELLENT	GOOD	GOOD	GOOD	EXCELLENT

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NEWS...

Low Rates Paid by City Cause Hospital Deficits, U.H.F. Report Declares

NEW YORK.—A large part of the deficits of voluntary hospitals here is caused directly by low rates paid to hospitals by the city for indigent care, Roy Larson, president of the United Hospital Fund, said in the fund's annual report released here last month. Mr. Larson said hospitals were losing $5.50 a day on ward patients with per diem costs at approximately $13, of which the city paid only $7.50 for care of charitable cases.

"Voluntary hospitals do not contend that the city should pay the full cost of this care because it is part of their obligation to the community to provide as much care as possible for those who cannot afford to pay all costs," Mr. Larson said. "On the other hand, it is felt that the city's payment should be greater in proportion to costs."

The report expressed appreciation for an advance in the amount paid hospitals from $6 to $7.50 a day effective last July 1. However, "although helpful, this increase is still greatly disproportionate to the actual cost in voluntary hospitals," Mr. Larson added.

Also listed as contributing causes of hospital deficits were inadequate payments for Blue Cross patients and lack of coordination in interpreting voluntary hospitals to the public and obtaining contributions.

Need Many More Medical Social Workers in Hospitals

NEW YORK.—Hundreds of medical social workers are needed to serve in voluntary hospitals here, Mrs. Edith G. Seltzer, director of social service consultation of the United Hospital Fund, said last month. Approximately 350 social workers are employed in voluntary hospitals in New York today, Mrs. Seltzer said. "That number should be doubled to meet present needs," she declared.

"Every hospital that has a well trained social service department gets innumerable calls from physicians to help private and semiprivate patients and is frequently unable to offer this service because it is so understaffed," Mrs. Seltzer said. "It is good use of professional learning and skill to give case work service at the point where illness is first discovered," she concluded.

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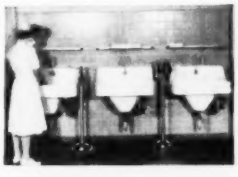

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NEWS...

N.Y. Council Report Analyzes Effect of Insurance Plans on Hospital Finances

NEW YORK.—Blue Cross service benefits rather than cash indemnity for hospital expense supplied the impetus which hospital insurance needed in order to make it generally acceptable, the Hospital Council of Greater New York stated in its *Bulletin* last month in a report which analyzed the impact of hospital insurance plans on the finances and services of hospitals.

The council report compared the Blue Cross plan in New York City and a group of thirty representative voluntary hospitals. The *Bulletin* noted that "27.3 per cent of all the patients treated in these thirty hospitals in 1947 were Blue Cross subscribers. In 1941 the percentage was only 13.6. The patient days of care show a similar increase—from 11.9 per cent in 1941 to 24.5 per cent in 1947.

"The number of Associated Hospital Service patients treated in these hospitals increased more than 130 per cent from 1941 to 1947," the *Bulletin* continued. "During the same period, the total number of patients treated in these same hospitals increased only 16 per cent." Commenting on these increases, the *Bulletin* explained, "Naturally, the effect of the growth in the Associated Hospital Service has been a change in the source of much of the hospitals' income."

Comparing the increases in payments in the New York Blue Cross plan to the increase of 125 per cent in the inpatient operating expenses in fifty-two general voluntary hospitals between 1938 and 1947, the council pointed out that, "Although Associated Hospital Service adjusted its rates of payment to hospitals to meet higher costs, the major part of the increased payments was due to the increase in enrollments."

Together, Blue Cross plans and other types of hospital insurance provided hospital expense coverage for nearly 53,000,000 individuals in the United States last year, the *Bulletin* said. Pointing out that many of the individuals so covered may be expected to seek semiprivate accommodations, the council advised hospitals "to plan their facilities so as to meet this changing demand without the need for major alterations."

The *Bulletin* also announced the designation of the New York Polyclinic Medical School and Hospital as a participating hospital in the council's program.

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Documentary Film Aids Student Nurse Recruitment

CHICAGO.—A documentary film on student nurse recruitment is now being released by RKO-Pathe, it was announced here last month at the American Hospital Association headquarters. The film is now available for general distribution through neighborhood theaters, the announcement said.

"I am pleased to report that the finished movie far exceeds expectations," George Bugbee, executive director of the association, said in a letter to member institutions urging use and promotion of the film. "It is a dignified and effective film and will certainly call to the attention of many young girls of student nurse age the value of nursing as a career. I was particularly impressed with the restrained yet effective manner used in presenting the interest and importance of serving the sick."

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NEWS...

Approve Revision of SPR 193-42 for Shortening, Salad and Cooking Oils

WASHINGTON, D.C.—The standing committee for Simplified Practice Recommendation R193-42 (packages for shortening, salad oil and cooking oil) has approved a suggested revision of this recommendation and copies have been mailed to producers, distributors and users for approval or comment, according to an announcement made here last month by the commodity standards division of the National Bureau of Standards.

A proposed change from the 48 pound size to a 50 pound size as a standard package for shortening was submitted to industry in February 1948 for acceptance or comment and was generally approved, the announcement said.

It is now proposed to add a shipping case of twenty-four 1 pound packages of shortening as a recommended standard stock shipping unit. It is further recommended that the 8, 6 and 4 pound package for shortening and the ½ gallon package for oils be eliminated from the list of standard stock packages in the interest of economy and good marketing practice, it was explained. A copy of the proposed revision can be obtained from the commodity standards division, National Bureau of Standards, Washington 25, D.C.

Dedicate Addition to Reese Hospital Clinic

CHICAGO.—Two new floors were dedicated at Michael Reese Hospital's Mandel Clinic here last month, according to an announcement from the hospital. The addition was built with a $250,000 contribution from Edwin F. Mandel, the announcement said, and will house children's and psychiatric outpatient services.

Dr. Morris Kreeger, hospital director, said that the fifth floor will include a children's playroom with motion picture facilities, the general pediatric clinic, special children's clinics, and a food clinic. The sixth floor will be devoted entirely to psychiatry service, bringing together in one central location the outpatient psychiatry clinics, the psychologists' laboratory, and a psychiatric social service students' unit, Dr. Kreeger stated. It is planned to set aside one room for sodium pentothal treatment, he added.

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NEWS...

D.C. Corporation Counsel Clarifies Definition of "Medically Indigent" Cases

WASHINGTON, D.C.—For purposes of charitable aid for hospital and medical care, Vernon E. West, District of Columbia corporation counsel, ruled here last month that "persons do not have to be destitute in order to be considered indigent." The ruling was welcomed by hospital and Community Chest groups which sought clarification of the status of indigents. Heretofore, it was explained, the city would pay only for patients who could afford to pay no part of their hospital and medical expenses.

Before standards defining indigency in terms of family income and property ownership are set up and put into operation, however, the corporation counsel's ruling was scheduled for clearance with the District comptroller-general.

The ruling was described as "a long step in the direction toward a more equitable use of all funds available for the care of those who cannot afford to pay in full their necessary hospital bills," by Chester Morrill, chairman of the hospital fund of the Community Chest.

William R. Castle, president of the Hospital Council of the Capital Area, said the decision made it possible to clarify a situation which deeply concerned the hospitals.

V.A. Gets Naval Hospital

WASHINGTON, D.C.—Acquisition of the 1000 bed U.S. Naval Hospital at Houston, Tex., by the Veterans Administration and cancellation of V.A. plans to construct a 1000 bed neuropsychiatric hospital at Houston were announced here last month by Carl R. Gray Jr., administrator of veterans' affairs. Transfer of the naval hospital will result in a savings of $21,000,000 in construction costs, it was estimated.

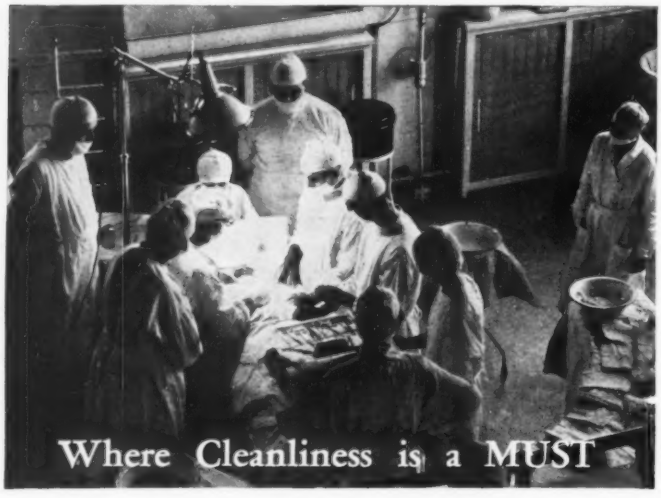
Mr. Gray pointed out that the action is in the interest of more effective utilization of federal hospital facilities and will avoid operation of two large neuropsychiatric hospitals side by side in the same community.

Start Cancer Research Unit

NEW YORK.—Plans for the $2,000,000 cancer research unit at the Columbia-Presbyterian Medical Center here have been completed and construction will be undertaken early in 1949, Dr. Willard C. Rappleye, dean of the university's faculty of medicine, announced last month. The new unit will consist of three floors of laboratory facilities to be added to the Vanderbilt Clinic building at the medical center, Dr. Rappleye said. Half the cost of the project is provided under a grant from the National Advisory Cancer Council, he said.

U.M.W. Benefits Start

ST. LOUIS.—Hospital and medical care benefits under the social security program of the United Mine Workers of America began last month, Dr. Cecil A. Sharp, director of the local U.M.W. welfare office here, said. For the time being, it was explained, medical and hospital care for miners eligible to receive benefits will be paid for through existing community hospitals and clinics. The U.M.W. has no present plan to build its own hospitals, Dr. Sharp said.



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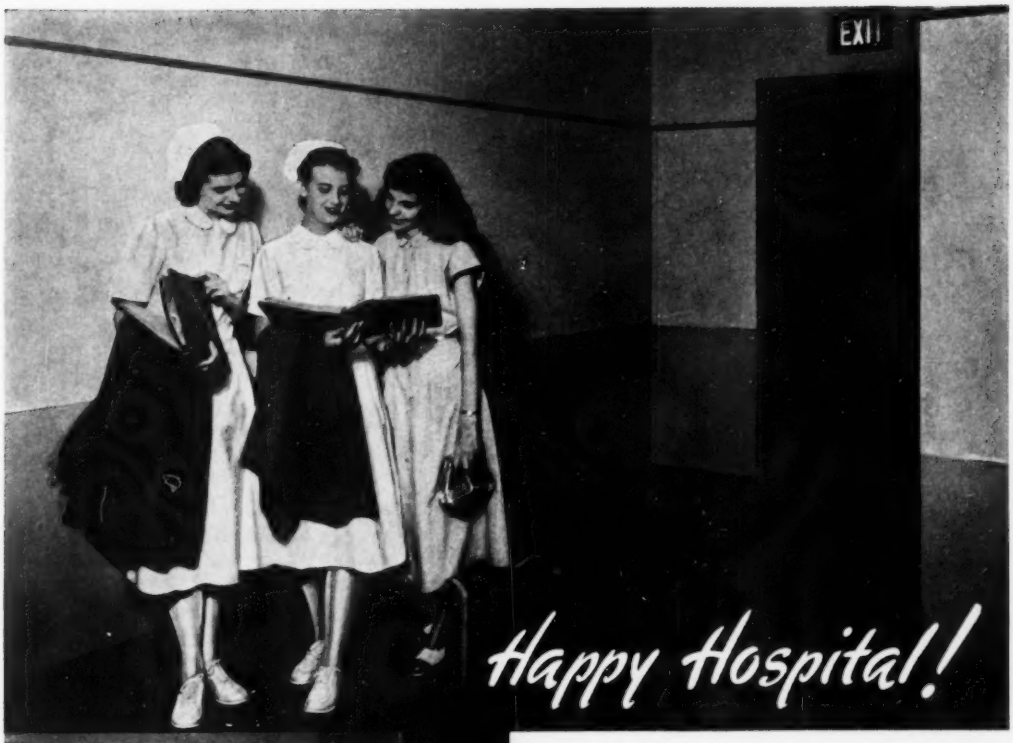

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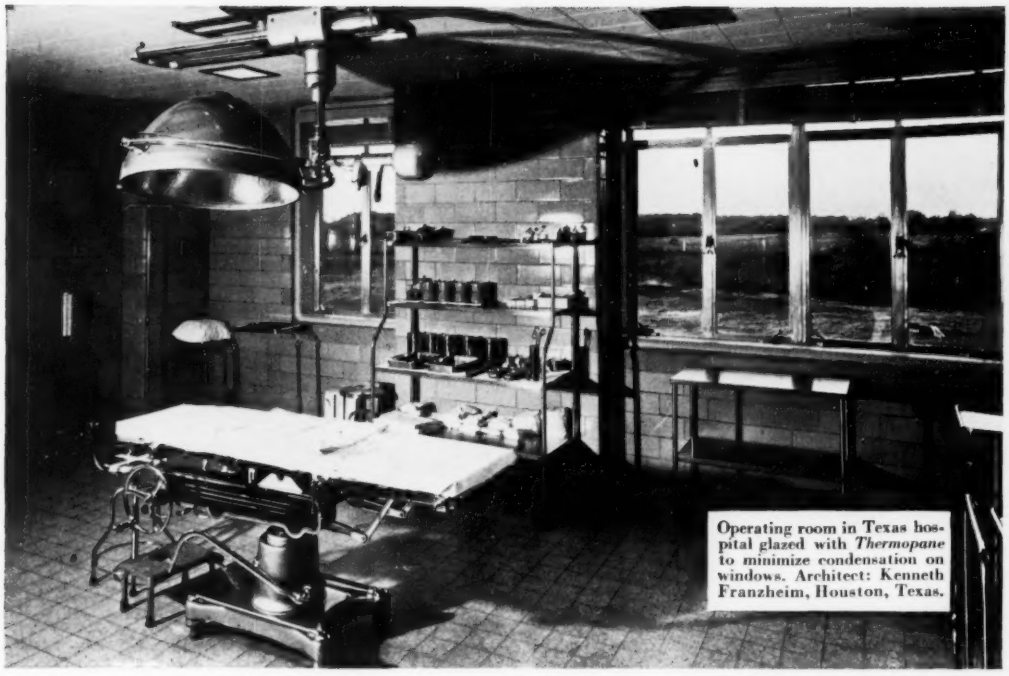

Operating room in Texas hospital glazed with *Thermopane* to minimize condensation on windows. Architect: Kenneth Franzheim, Houston, Texas.

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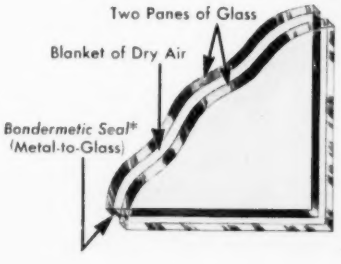

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NEWS...

Change Title of Hospital Interns to "Residents"

NEW YORK—The term "administrative resident" will be used hereafter in place of "administrative intern" to designate hospital administration course graduates who are taking their year of postgraduate practical training in hospitals affiliated with the various university programs, it was decided at a meeting of the Association of University Hospital Administrative Course Directors here last month. After considerable discussion, the directors decided that the term residency was a more nearly accurate description of the postgraduate training period than the present label of internship.

The directors also agreed upon a timetable to govern appointment of students to hospital residencies. Students will be permitted to contact hospitals informally at Christmas time each year; this provision recognizes the fact that many students like to make personal visits to hospitals to discuss the residency appointment during the Christmas holidays. However, the course directors will not communicate their residency recommendations to hosiptals before February 1, and students will be notified of their residency appointments by March 1 each year.

Another date that was agreed on by the directors was an April 1 deadline for notification of candidates for admission to the course for the following fall term.

The directors discussed the relationship between their group and the American College of Hospital Administrators in conducting research in all phases of the education program. Also discussed was a proposed research program aimed at setting up tests to improve methods used in the selection of students.

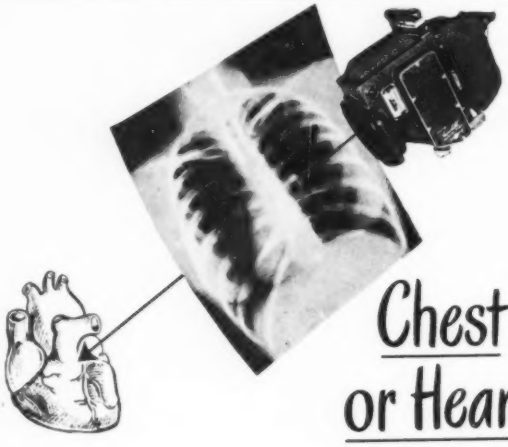
Extension Course for Hospital Housekeepers to Start at Michigan State

CHICAGO.—An eight weeks' course in hospital housekeeping will be inaugurated at Michigan State College, East Lansing, Mich., April 4 and will run through May 27. The course will be sponsored by the American Hospital Association and Michigan State College.

Ten courses of study will be covered during the eight weeks, with lectures, discussion and quiz periods for theoretical study and laboratory periods for practical training. Studies include: philosophy of hospital care and institutional organization; personnel management; job analysis; housekeeping supplies, equipment and procedure; linens, furnishings and decorations; bacteriology; fire prevention and safety; practical speaking; budgeting and record keeping; employe training, and general cleaning.

The enrollment fee will be $32 for residents of Michigan and an additional $50 for out-of-state students. Housing at a dormitory will cost $48, including laundry and linen, and meals at the dormitory dining room will cost $99.90 additional. Total cost to Michigan residents, including textbooks, will be $200, and to out-of-state registrants, $250. Registration will be limited to fifty.

The course is designed to add further to the abilities of persons already employed in hospitals, to enable those just coming to hospitals as housekeepers to start with greater knowledge of the job, and to stimulate other persons to select hospital housekeeping as a career.



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SPEED: 1200 or more X-ray exposures can be taken in a single day. Routine or test shots can be processed immediately after exposure. Angiographic shots can be taken at the rate of 16 or more every 10 seconds depending on the size of the patient to provide an adequate record for accurate diagnosis.

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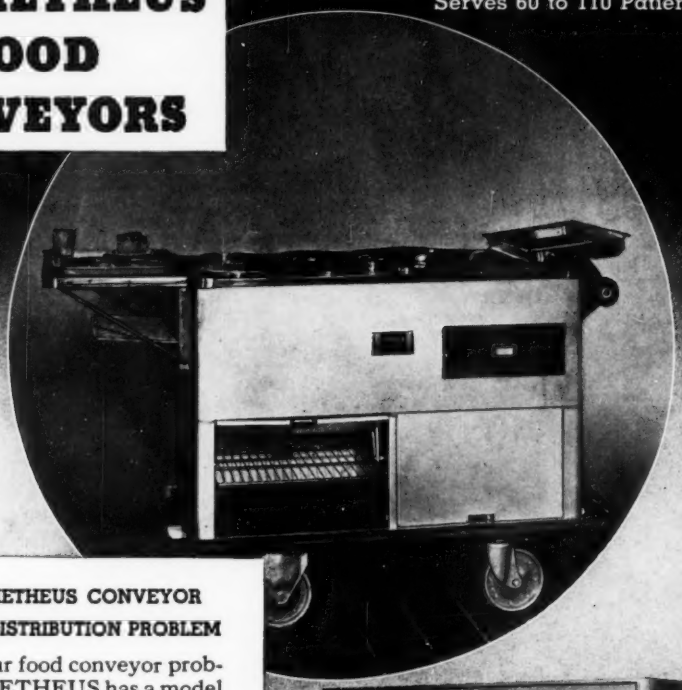
PROMETHEUS FOOD CONVEYORS

Standard Model No. 1038
Serves 60 to 110 Patients



THERE IS A PROMETHEUS CONVEYOR FOR EVERY FOOD DISTRIBUTION PROBLEM

No matter what your food conveyor problem may be, PROMETHEUS has a model to meet your requirements or will design a special conveyor to fill your individual needs. The engineering and manufacturing experience of our organization is at your service for this purpose.

PROMETHEUS conveyors are scientifically designed for greatest efficiency in practical day by day operation. They are strongly built of the finest materials and will give many years of satisfactory service. Backed by 40 years of experience, PROMETHEUS food conveyors have no superior.

PROMETHEUS conveyors are attractive in appearance, compact in size, easy to handle, economical in cost, economical to operate and use a minimum of current. Approved by Underwriters Laboratory.

Send for descriptive circular giving full details of various designs, capacity and special features.

PROMETHEUS electrically Heated tray conveyor. For central tray service or special diet service. Sturdily constructed, attractively designed and extremely mobile.

PROMETHEUS tray conveyors offer the perfect solution to many hospital problems of food service.

PROMETHEUS ELECTRIC CORP., 401 WEST 13TH ST., NEW YORK 14, N. Y.

NEWS...

TB Patients Protest Overcrowding at Bellevue

NEW YORK.—Tuberculous patients at Bellevue Hospital petitioned Mayor O'Dwyer to take immediate action to relieve crowded conditions in the hospital, newspapers reported last month. More than 200 of Bellevue's 550 tuberculous patients signed the petition, it was reported.

In tuberculosis wards, patients' beds line the corridors, the petition stated. Dr. William F. Jacobs, hospital superintendent, said that 131 patients occupied beds in the hospital corridors. "We appreciate that placing these patients in the halls is not desirable," Dr. Jacobs stated, "but it is more desirable than leaving them on the streets. At least they get plenty of bed rest and good food here." Dr. Jacobs predicted that most of the 131 patients would be out of the hospital within a short time. They were to be transferred to other city institutions where preparations were being made for their care.

No Matching Problem!

Now physicians and their technicians can eliminate the fuss and bother of matching syringe barrels and plungers.

The new Bishop Sempra® Syringe, another product of Bishop research, makes this possible. *All* barrels and plungers of a size are *completely* interchangeable. No identifying numbers are used because none are needed.

Sempra Syringes are thrifty, too. They save both time and money. There is no time-consuming fishing in the sterilizer for matching parts. And if you break a barrel or plunger, *any other* will fit.

Hospital administrators, physicians and nurses will like these additional new features, too—the indestructible ceramic markings, the strong permanent metal tip, and the corrosion-resistant glass. All these improvements will save you time, temper and trouble. Ask your regular supplier for details.

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SERVICE TO SCIENCE AND INDUSTRY SINCE 1842

Plan Medical Program for Proposed New York State University

NEW YORK.—The Long Island College of Medicine in Brooklyn, N.Y., the Syracuse College of Medicine and New York University College of Dentistry may become a part of the proposed state university of New York, according to plans reported here last month. Officials of the schools have offered their facilities for integration in the medical program of the projected state university. Trustees of the state university are considering the comparative advantages of constructing new schools and taking over existing institutions. The university plans to operate one medical center in the metropolitan area and another elsewhere in the state.

U. of Illinois Installs 22,000,000 Volt Betatron

CHICAGO.—A 22,000,000 volt betatron was installed at the University of Illinois hospital here last month. The betatron measures 36 inches by 81 inches and weighs five and one-half tons, the university reported. Control equipment weighing an additional five tons was a part of the installation, it was explained.

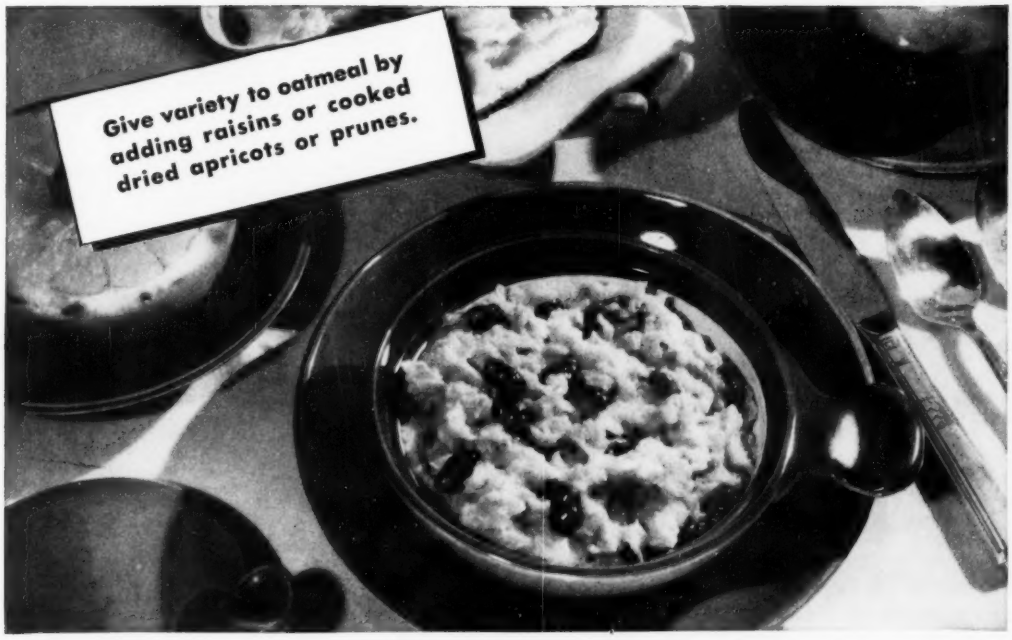
The betatron is housed in a separate building immediately south of the university hospital. Most of the structure is underground so that surrounding earth can be used to provide an effective x-ray barrier. A tunnel connects the betatron building and the hospital, it was explained.

The betatron will be used in cancer treatment and research, the university announcement said.

N.W. Texas Officers Elected

EL PASO, TEX.—Maud Cooze, administrator of Sweetwater Municipal Hospital, was named president-elect of the Northwest Texas Hospital Association at the association's annual meeting here recently. W. U. Paul, administrator of Southwestern General Hospital, El Paso, took over the presidency from Alvah Conner of Wichita Falls, during the meeting.

Other officers named by the association were: vice president, Wayne Holmes, Wichita Falls; trustees, Don Burk, Big Spring, T. C. Scott Jr., Stephenville, and Ross Urban, Fort Worth.



Now Cook Oatmeal this *EASIER* Way

Doctors and dietitians have long agreed that oatmeal ranks first in nutritive value among cereals. In high protein, food energy, vitamin B_1, and iron content, it leads all other whole grain breakfast foods.

Fortunately, the easiest method of cooking oatmeal gives you this highly nutritious breakfast food at its best—flaky in texture—nut-like in flavor and yet completely cooked. The secret lies in less stirring and a shorter cooking time.

TO MAKE 50 OATMEAL SERVINGS

(Recipes from Quaker Institutional Test Kitchen.)

DIRECT HEAT METHOD: Into 10 qts. of briskly boiling water put 3 tbsp. of salt. Stir in 3 pounds of Quaker Oats (Quick or Old Fashioned). Cook 2½ to 5 minutes (longer if preferred). Stir occasionally.* Turn off heat and let stand for 5 minutes.

DOUBLE BOILER METHOD: Add salt to water. Heat to boiling. Add Quaker Oats gradually, stirring just enough to prevent lumping. Place top of double boiler over bottom filled to ⅓ capacity with boiling water. Cover and cook 10 to 20 minutes (or longer), stirring occasionally.*

**Stir with a light "fold-over" motion and just enough to get even texture and even cooking throughout.*

FREE! NEW WEEKLY MENU PLANNER

If you have used the Quaker Oats Weekly Menu Planner, you know how much "pencil and ruler" work these pads save you. The new deluxe two-color Menu Planner is protected by an attractive cover. It contains a 6 months' supply of menu blanks and Quaker products order blanks. Each sheet has ample room for an entire week's menus with a handy margin for jotting down notes. Remember, it's *free*. Ask your supplier for your new Quaker Menu Planner.

THE QUAKER OATS COMPANY
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NEWS...

Great Britain Raises Pay of Student Nurses

CHICAGO.—In an effort to recruit nurses needed to staff hospitals under the new government medical program, the Ministry of Health in Great Britain has substantially increased the stipend paid to student nurses, according to a London dispatch to the *Chicago Tribune*. Approximately 15 per cent of Great Britain's hospital wards are closed for lack of nurses, the report said, while demands for hospital space are mounting rapidly under the government health plan.

Student nurses formerly received $280 a year, it was reported. Under the new plan, they will receive $800 for the first year and an annual increase up to $1000 in the third year.

Nevertheless, it was explained, the increases are not as great as it might appear since students must pay taxes and reimburse hospitals for room and board.

Graduate nurses now receive stipends varying from $560 to $1040 a year, plus living allowances, it was explained.

For that first breath of life you can rely

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A rhythmic alternation of gentle pressure and suction has been found absolutely safe and maximally effective in the studies of Ivy, Schwerma, Thompson, Birnbaum, Martinez, Coryllos, and others.

A single lever control averts the danger of confusion in emergencies.

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May we demonstrate or send you further information?

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N.Y.-Bellevue Medical Center Construction Costs Doubled

NEW YORK.—Total cost of construction for the proposed New York University-Bellevue Medical Center will be more than $32,000,000, approximately twice the original estimate of construction cost, it was announced here last month by Edwin A. Salmon, medical center director. The new plans call for undergraduate and graduate medical schools, a specially designed wing for the institute of rehabilitation, and a 600 bed university hospital designed primarily for middle income patients.

A grant of $8,000,000 to underwrite the graduate medical education phase of the program was also announced. The donation was made by the Samuel H. Kress Foundation of New York.

Nurses Start Psychiatric Training Program

WILMINGTON, N.C. — Affiliation of the Community Hospital Nursing School here with the New York University-Bellevue Medical Center, division of psychiatry, was announced last month by Frank B. Adair, administrator of the hospital. The first class of eight senior nurses left January 10 for a three-month training period, it was explained.

"This move is part of our effort to develop our school for nurses into one of the most creditable institutions of its kind to be found anywhere and to provide North Carolina's second largest hospital for Negroes with the best available professional services and hospital facilities for its purposes," Mr. Adair stated.

Centralized Purchasing Agency Proposed

WASHINGTON, D.C. — Hospital groups here met last month to consider establishing a central purchasing agency aimed at effecting economies through quantity purchases. Preparatory to discussion of the purchasing project, the Capital Area Hospital Council issued a list of fifteen items said to be available for group purchase "at better prices than most hospitals are paying," according to an official of the hospital council.

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A human life

often hangs upon a few seconds of skillful surgical action.
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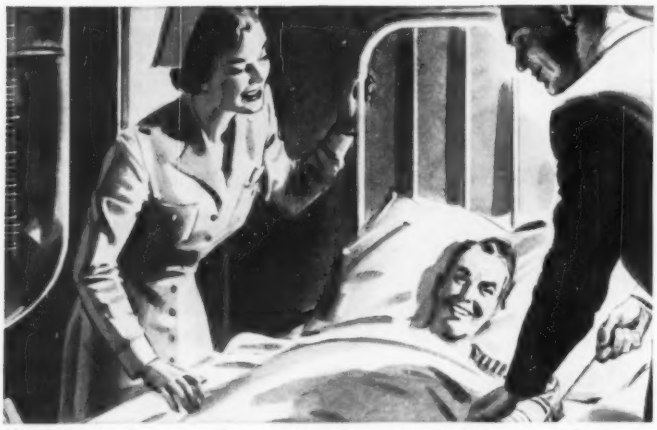
How SPEED helps a hospital help you



Vital drugs often come from scattered sources. And they must be fresh. Hospitals solve this problem and give you better service with the speed of Air Express. For example: 5-lb. drug carton picked up at 3:30 P.M. 700 miles away, delivered to hospital 9:20 P.M. same day. This speed saved a life—cost only $1.63!

Only $1.63—and door-to-door service included at no extra cost! Speedy pick-up and delivery, plus Airline speed, make low-cost Air Express the world's fastest shipping service.

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NEWS...

Business, Hospital Leaders Organize Advisory Group

CLEVELAND.—An employers' advisory committee which will serve as a medium for exchanging ideas between business and industrial leaders and hospitals has been organized by the Cleveland Hospital Council and the Cleveland Hospital Service Association, it was announced here last month by Guy J. Clark, executive secretary of the hospital council, and John R. Mannix, Blue Cross director.

"It is our feeling that mutual profit can result from continuous and close cooperation in matters of interest to employers, hospitals and the hospital service association," the announcement said. "We have been much gratified at the interest already shown by the industrial and business leaders who constitute the new committee."

Infant Diarrhea Outbreak Causes Six Deaths at Hibbing

HIBBING, MINN.—An outbreak of infantile diarrhea has caused the death of six babies at the Hibbing General Hospital here, a newspaper report said last month. Eight other infants were reported to be under treatment for diarrhea. Dr. Bernard F. Flynn, local health officer, said the hospital had been closed to visitors and that "every possible move" was being made to check the spread of infection.

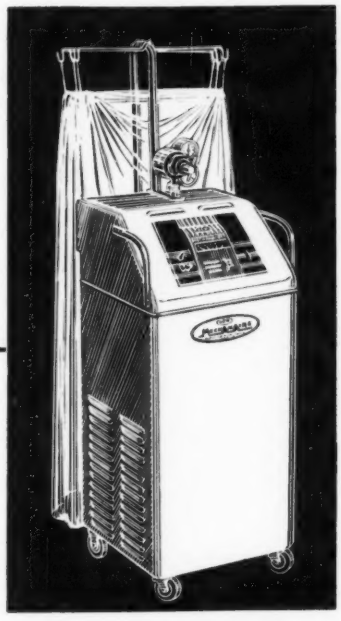
The public health officer said the infant diarrhea was apparently connected with an epidemic of diarrhea which occurred among adults and older children in the community.

Lowell Campaign Hits Goal

LOWELL, MASS.—The fund raising campaign to underwrite construction costs for a new maternity and pediatric building and a new nurses' home at the Lowell General Hospital here reached its goal last month when gifts totaling $1,050,932 were announced by Paul Spencer, administrator of the hospital. The campaign was the first drive for capital funds in Lowell for forty years, Mr. Spencer said.

OB Congress Dates Announced

The International and Fourth American Congress on Obstetrics and Gynecology will be held at the Hotel Statler in New York City, May 14 to 19.



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ABOUT PEOPLE

(*Continued From Page 79.*)

ceeding **Marie Hill,** who will continue her work as nursing educator at San Jose Hospital, San Jose, Calif. Mrs. Price is a graduate of Yale University School of Nursing and served on the faculty there as an instructor in nursing arts. She has a master's degree from Pomona College.

Margaret W. Treherne-Thomas has been appointed director of volunteers at New York Hospital, New York City.

Dr. Leo M. Davidoff has been appointed director of neurosurgery at Beth Israel Hospital, New York City. After his graduation from Harvard University School of Medicine, Dr. Davidoff received training in neurological surgery at the Peter Bent Brigham Hospital, Boston, which was followed by a traveling fellowship abroad.

Dr. Gail William Haut has been appointed radiologist at Morristown Memorial Hospital, Morristown, N.J., replacing **Dr. John D. Tidaback,** who is retiring from active practice after thirty-five years of professional service.

Trustees

Arthur A. Frank has been elected president of the Evanston Hospital Association, Evanston, Ill. A member of the board of directors since 1940, Mr. Frank is chairman of the board of the Standard Railway Equipment Company, Chicago.

Winthrop Rockefeller has been elected chairman of the board of trustees of New York University-Bellevue Medical Center, New York City, succeeding **Dr. Samuel A. Brown,** who was appointed acting chairman last fall after the death of **Richard W. Lawrence.** Dr. Brown is now vice chairman.

Samuel Stewart, for twenty years chairman of the board of Central Maine General Hospital, Lewiston, Me., has resigned, being succeeded by **Gilbert D. Harrison.** Mr. Stewart continues as a member of the board, as president of the hospital corporation, and as a member of the committee in charge of the hospital's construction program.

Miscellaneous

Dr. Marcus Kogel has been named Commissioner of Hospitals for New York City, succeeding **Dr. Edward M. Bernecker,** who retired to accept an executive position with the New York University-Bellevue Medical Center. Prior to his new appointment, which became effective February 1, Dr. Kogel was general medical superintendent of the New York City Department of Hospitals. **Dr. I. Herbert Scheffer** was promoted recently from medical superintendent of Metropolitan Hospital to general medical superintendent of the City Hospital Department.

Dr. Samuel M. Wishik, former assistant director of the division of health services of the United States Children's Bureau in Washington, has been named head of New York City's newly reorganized Bureau for Mothers and Young Children.

E. J. Henryson has retired as the director of Group Hospitalization, Inc., Washington, D.C., a position he had held since February 1934. Mr. Henryson, who helped to establish the hospital service plan sixteen years ago, has been succeeded by **F. P. Rawlings Jr.**

Leonard McHugh, formerly general storekeeper at the New York Hospital, New York City, has been appointed assistant director of the Hospital Council of Greater New York.

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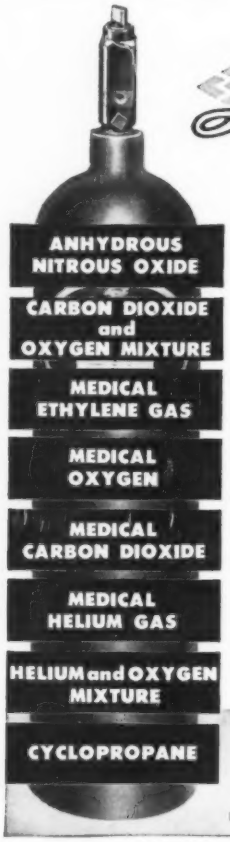

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Because of their beautiful wood faces, Weldwood Fire Doors harmonize perfectly with any decorative scheme.

3. *Durability*

The Underwriters' Laboratories tested a Weldwood Fire Door for durability by mechanically opening and closing it 200,000 times. At the end of the test, the door was unaffected and still opened and closed perfectly.

4. *Dimensional Stability*

Weldwood Fire Doors are so dimensionally stable that we guarantee them against sticking in summer or rattling in winter due to any dimensional changes in the door.

5. *Light Weight*

At last . . . a real fire door that is *not* heavy or unwieldy. A standard 3 x 7 door weighs approximately 80 lbs.

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The mineral composition core used in Weldwood Fire Doors is permanently resistant to fungus, decay, and termites.

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Another noteworthy characteristic of the core is its high insulating value over a wide range of temperatures. It is efficient against temperatures from freezing up to that of superheated steam.

8. *Moderate Cost*

Investigate these doors for use on your next job. You will be pleasantly surprised at the low initial cost, and the minimum of maintenance required.

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FIRE DOOR FOR OPENING IN VERTICAL SHAFT
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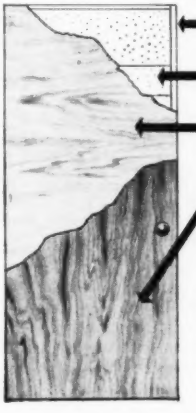
NOW... plan on permanent fire protection *plus* the rich beauty of real wood! Here at last is an absolutely fire-safe door that is also a decorator's delight.

Thanks to the handsome hardwood facing that distinguishes this unique Weldwood Door, you can plan on bringing extra beauty to every room. Yes, these beautiful new Weldwood Doors help you to carry your decorative theme throughout the building . . . while giving you lasting fireproof construction!

Write today for complete information. You'll also want full details about the new *Weldwood Flush Veneer Door* for use where absolute fire protection is not required.



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Of fireproofed hardwood matches the faces.

MINERAL CORE
Strong, light fireproof material. Great dimensional stability.

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Of 1-16" veneer is bonded to mineral core.

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Is birch. Other decorative woods available on special order.

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NEWS...

Deaths

John R. Stone, administrator of the Menninger Clinic at Topeka, Kan., died January 11 after an illness of several months. Mr. Stone had been associated with the clinic for twenty-five years as, successively, psychologist, business manager, administrator and partner. He also served as vice president and a member of the board of directors of the Menninger Foundation, an associated enterprise.

Mr. Stone was one of the organizers and early supporters of Blue Cross in Kansas and had been president of the Kansas Hospital Service Association since 1942. He was also active in hospital association work, having been president of the Kansas Hospital Association and chairman of the Topeka Hospital Council. He was a member of the American College of Hospital Administrators and a frequent speaker at hospital and Blue Cross meetings. Mr. Stone was 49 years old at the time of his death.

Dr. Hugh Smith Cumming, surgeon general of the United States Public Health Service from 1920 to 1936, died December 20 at his home in Washington, D.C. It was during Dr. Cumming's administration of the Public Health Service and the important Pan American Sanitary Bureau, of which he had been director for twenty-seven years, that public health came to be recognized in the United States as a major responsibility of government in international as well as domestic affairs.

William E. P. Collins, formerly administrator of Staten Island Hospital, Staten Island, N.Y., died suddenly January 12 at his home on Staten Island. He was 57 years old. Prior to his Staten Island appointment, Mr. Collins was identified with Lenox Hill Hospital, New York City, as assistant to **John H. Hayes,** administrator.

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THE BOOK SHELF

A STUDY OF NURSING SERVICE *in One Children's and Twenty-One General Hospitals. National League of Nursing Education. New York.* 1948. Pp. 63.

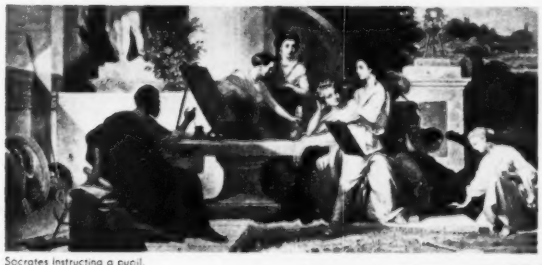
This timely study highlights the fact that in general, hospitals have not yet begun to utilize trained practical nurses and nurse's aides to the greatest possible extent. The fact that the study disclosed that in all types of hospitals an average of approximately 68 per cent of total bedside nursing hours are performed by professionals with only 32 per cent by nonprofessionals should cause some intensive thinking on the part of hospital administrators and directors of nursing service. Experience pretty clearly indicates that at least 65 per cent of the total bedside care can and should be given by nonprofessionals.

The lists of duties performed by nurse's aides are valuable and the general discussion of the use of teams consisting of one professional nurse and one nurse's aide and/or trained practical nurse is enlightening.

The data given on average hours per patient per day actually given and the figure of hours considered necessary for good nursing service are worth study, with some follow-ups by every hospital administrator and nursing service director in their own hospitals to get similar figures.—E. W. JONES.

"No physician, in so far as he is a physician, considers his own good in what he prescribed, but the good of the patient . . . That has been accepted? Yes."

Plato, Republic



Socrates instructing a pupil.

Physicians established their code of ethics many centuries before the advent of scientific medicine. In the fifth century B.C., the code was already so firmly accepted that Socrates used it to illustrate a point during one of the most celebrated conversations in literature.

Most important advancements of scientific medicine have occurred during the last few decades. During these years, **MALLINCKRODT** original research and manufacturing skill have supplied an important share of the products which physicians "prescribe for the good of the patient."

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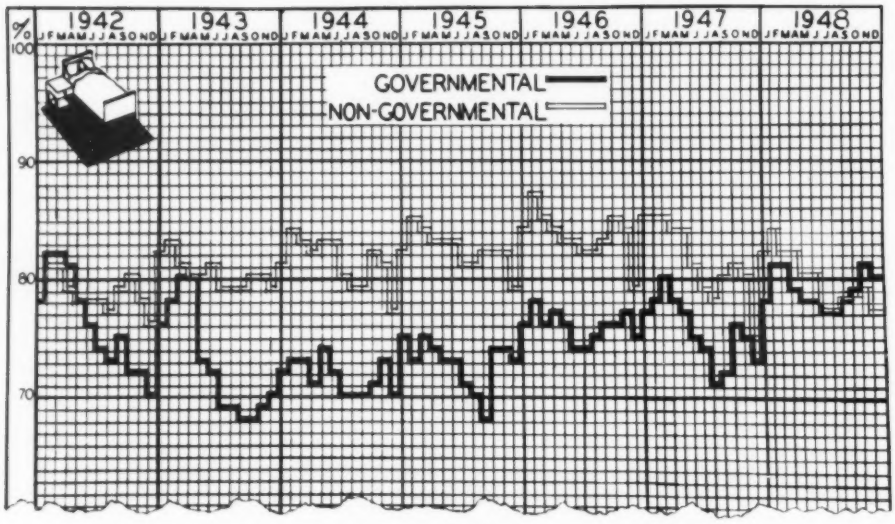
Uniform Dependable Purity

Occupancy in Governmental Hospitals Rises



In the month of December, occupancy of nongovernmental hospitals continued at somewhat lower levels than have prevailed generally throughout the last two years. Voluntary hospitals reporting to the Occupancy Chart were 77.3 per cent filled for the month, somewhat below the previous month. Occupancy of governmental hospitals, on the other hand, is creeping upward—the figure for December was 80 per cent, 7 points above December 1947.

Hospital construction reported for the first 1949 period totaled $53,864,495, up more than 10 per cent over the same period last year. Projects reported included 27 new hospitals costing more than $1,000,000 apiece.

RESTORES YOUR FLOORS

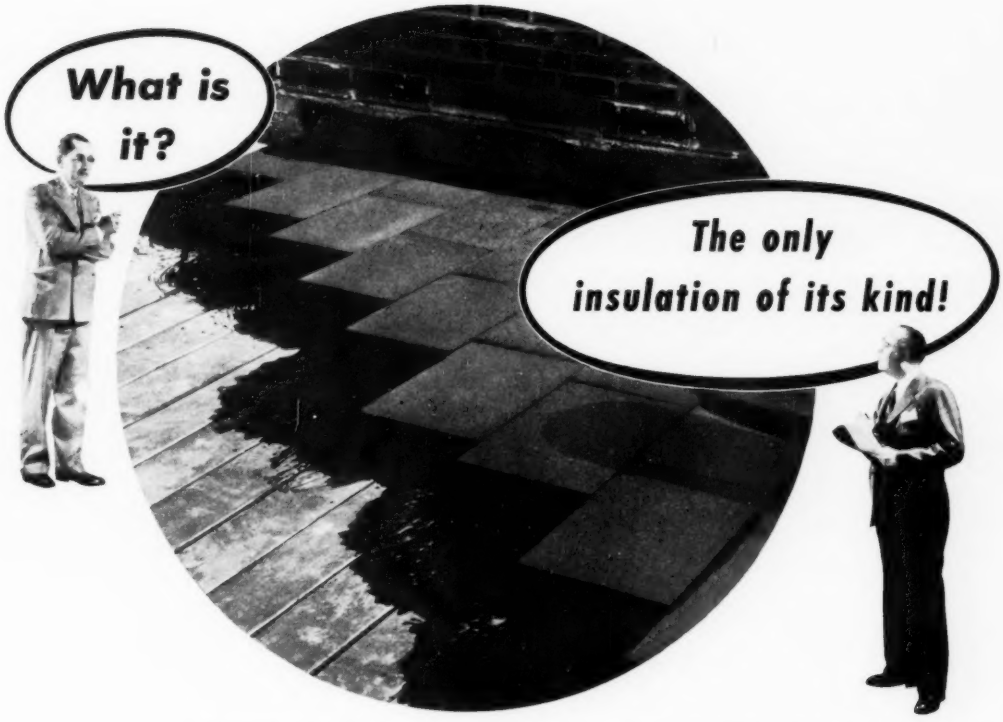
Super
SHINE-ALL

Serves the three fold purpose of Cleaning, Polishing and Preserving the surface. Safe for all types of floors and woodwork. A neutral, liquid chemical cleaner dissolves grime and dirt. Efficient and Economical. Not being a soap or powder it does not have to be rinsed. Has stood the Test of Time for almost Half a Century.

There is a trained Hillyard "Maintaineer" in your vicinity. Call, write or wire for his advice on any floor problems. No obligation.

HILLYARD SALES COMPANIES

470 Alabama St., San Francisco 10, Calif. DISTRIBUTORS HILLYARD CHEMICAL CO. ST. JOSEPH, MO. BRANCHES IN PRINCIPAL CITIES 1947 BROADWAY, NEW YORK 23, N. Y.

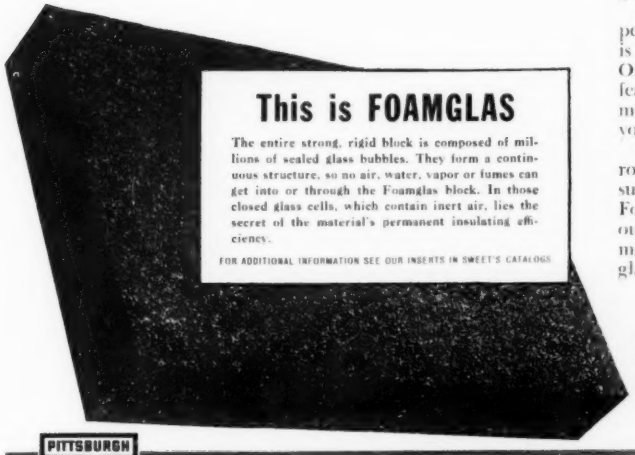


● You have never seen any material like PC Foamglas. It looks solid, but is composed of millions of tiny sealed cells of *glass*. It is feather-light, yet will not crush when you stand on it.

Since it consists of cellular glass in the form of big, rigid blocks, PC Foamglas has outstanding insulating properties. And since glass is impervious to practically all elements that attack insulating materials, PC Foamglas retains its original insulating efficiency.

Executives who figure insulation on a cost-per-year basis, can tell you that PC Foamglas is the most economical insulating material. Once it is properly installed, you need not fear costly repairs, maintenance or replacement. With PC Foamglas, your first cost is your last cost.

When you are figuring on insulation for roofs and ceilings, for walls and floors, be sure you have complete information on PC Foamglas. Meanwhile, why not look over our most recent booklets on insulation? Just mail the convenient coupon and we shall be glad to send you *free* copies.



This is FOAMGLAS

The entire strong, rigid block is composed of millions of sealed glass bubbles. They form a continuous structure, so no air, water, vapor or fumes can get into or through the Foamglas block. In those closed glass cells, which contain inert air, lies the secret of the material's permanent insulating efficiency.

FOR ADDITIONAL INFORMATION SEE OUR INSERTS IN SWEET'S CATALOGS

Pittsburgh Corning Corporation
Dept. U-29, 307 Fourth Ave.
Pittsburgh 22, Pa.

Please send me without obligation, your free booklets on the use of PC Foamglas Insulation for:

Roofs..... Walls..... Floors.....

Name.....

Address.....

City..... State.....

PITTSBURGH PC CORNING ® **FOAMGLAS INSULATION**

. . . when you insulate with FOAMGLAS . . . you insulate for good!

You helped SIMMONS design a far better BED SPRING!

"I want a spring that handles easily — no matter what the patient weighs."

The DECKERT

THE FLEXIBLE CENTER SECTION MAKES THE DIFFERENCE!

Bed illustrated: H-829-L-171

The flexible center section gives the Deckert Spring *four* movable, adjustable sections. That is why the spring can be adjusted to 18 standard positions — six more than formerly possible! The "wing" section permits:

1. **Easy adjustment for any medical or surgical treatment.**
2. **Simplified, jiffy bedpan service.**
3. **Adjusts to Trendelenburg or Fowler positions without use of elevating stems or blocks.**
4. **Adjustment for cardiac and eye treatments.**
5. **Improved orthopedic and fracture positions.**
6. **Special hyperextension positions, and many others.**

"I want a spring that saves my nurses' time and energy; and keeps patients comfortable under all circumstances."

"I want a spring that brings my patients to the proper positions for any medical or surgical treatment comfortably."

"I want a spring that gives trouble-free service—and a spring that pleases doctors and nurses."

Multi-position Spring

with a flexible center section!

It really was your idea—this practical, Simmons improved Deckert Multi-position Spring. It was designed only after Simmons consulted nurses, supervisors, doctors and administrators.

You wanted a sturdy, easily maneuverable spring that would enable you to put a patient into a maximum number of positions for treatment or comfort, with the least physical effort. So Simmons re-designed and improved the Deckert Multi-position Spring—added a *flexible "wing" center section!*

Here is a spring unequalled for maneuverability, usefulness, simplicity of action, sturdy construction, long life, and patient comfort!

Every new hospital should include the versatile Deckert Multi-position Spring in its budget. And, no established hospital should select new springs until administrators and the budget committee have seen this practical spring demonstrated. Why not buy for a lifetime of trouble-free service? See your nearest Simmons hospital supply dealer or write.

SIMMONS COMPANY
HOSPITAL DIVISION

DISPLAY ROOMS:

CHICAGO 54, MERCHANDISE MART • NEW YORK 16, ONE PARK AVENUE
ATLANTA 1, 353 JONES AVENUE • SAN FRANCISCO 11, 295 BAY STREET

WRITE FOR FREE DESCRIPTIVE FOLDER

Your Floors are On Duty 24 Hours a Day!

For *minimum* care and *maximum* service be sure those floors are TILE-TEX* Asphalt Tile

Hard-working nurses who cover the corridors have an easier time when the floors are of hard-working, easy-going Tile-Tex Asphalt Tile.

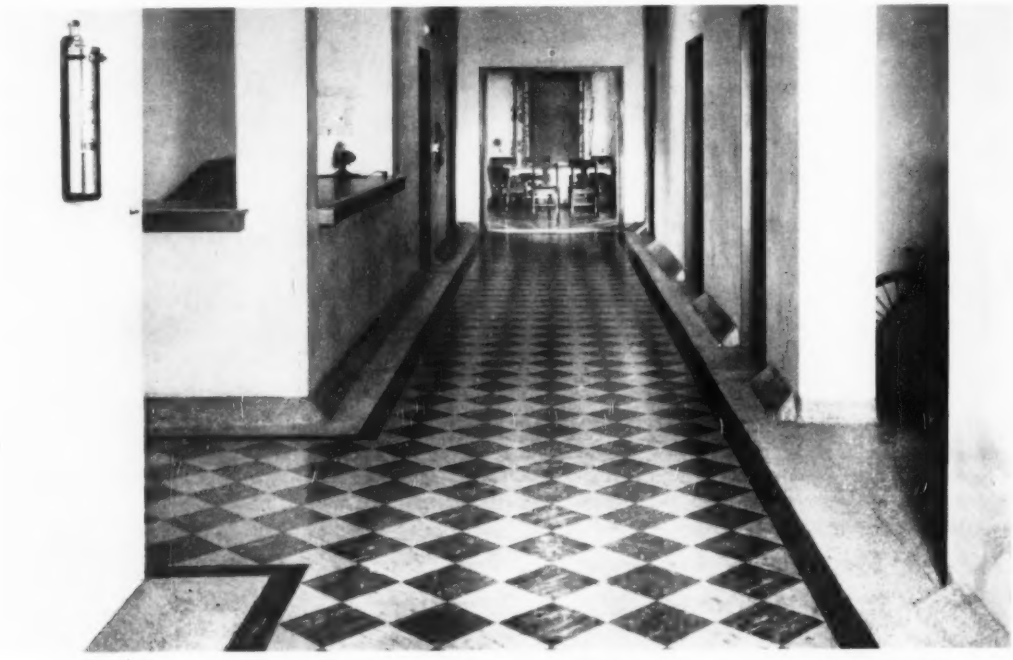
For, with this cheerful, resilient flooring material underfoot, nurses happily go their rounds without dread of aching feet. And because it's easier to take care of patients . . . the patients can expect better care.

A Tile-Tex floor is very easy to maintain. Cleanliness and sanitation become routine . . . not major operations . . . because its smooth surface can be cleaned quickly and with little effort.

Tile-Tex is tough and durable and offers many advantages in hospital use. Your architect will confirm the fact that Tile-Tex is also the only type of resilient flooring which can be installed with safety over a concrete slab in direct contact with the earth.

Talk to a Tile-Tex Flooring Contractor and learn how simply, economically and efficiently you can replace old, worn, unsatisfactory floors.

To find out how Tile-Tex Asphalt Tile can serve your flooring needs, write for special hospital folder and the name of the nearest Tile-Tex flooring contractor. THE TILE-TEX COMPANY, INC. (subsidiary of The Flintkote Company), Chicago Heights, Illinois. Sales offices located in Chicago, New York, Los Angeles, New Orleans, Montreal and Toronto.



Asphalt TILE-TEX CO. Tile

Tile-Tex Asphalt Tile

*REGISTERED TRADEMARK OF THE TILE-TEX COMPANY, INC.

AMERICAN-Standard

First in heating . . . first in plumbing

Architect: *Press C. Dowler, Pittsburgh*
General Contractor: *Henry Busse, Pittsburgh*
Plumbing Contractor: *Weldon & Kelley, Pittsburgh*
Heating Contractor: *Harry Dougherty, Freeport, Pennsylvania*

Ohio Valley General Hospital selects AMERICAN-Standard

■ There were good reasons why American-Standard Heating Equipment and Plumbing Fixtures were selected for the new 135-bed Ohio Valley General Hospital in McKees Rocks, Pennsylvania.

The staff knew, from experience in the hospital being replaced, that American-Standard products meet the most rigid hospital requirements... that they can be depended upon for years of efficient, economical service . . . that they afford easy maintenance.

If you are planning to modernize your present hospital building or to erect a new structure, your Designing Architect or Engineer and your Heating and Plumbing Contractor will gladly help you select the American-Standard Heating Equipment or Plumbing Fixtures best suited to your needs. **American Radiator & Standard Sanitary Corporation,** P. O. Box 1226, Pittsburgh 30, Pennsylvania.

SITZ BATH. Made of genuine vitreous china to assure strength and good looks, and a smooth, hard, easily cleaned surface. Improved design adds to comfort of the patient and convenience of the nurse. In ever-increasing demand in modern hospitals, whose administrators take pride in offering patients the best and most complete facilities.

WATER CLOSET COMBINATION made of genuine vitreous china is sturdy, good looking, easy to keep clean. Syphon jet flushing action assures thorough, quiet operation. As shown with bedpan cleanser and lugs, it is ideal for toilet rooms adjacent to private or semi-private rooms.

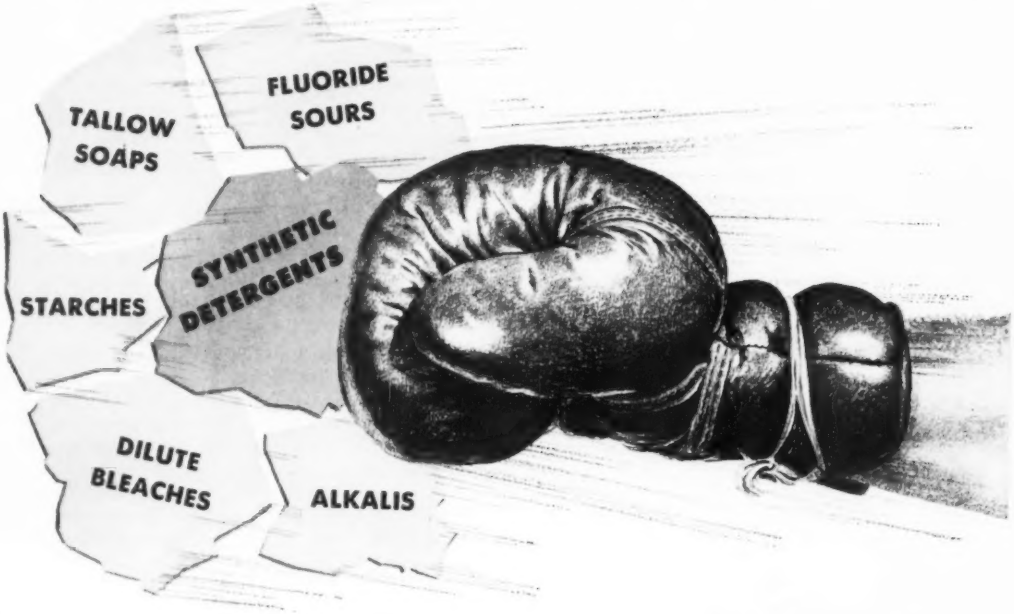
Look for this AMERICAN-Standard PLUMBING PRODUCTS *Mark of Merit*

SCRUB-UP SINKS have deep bowls to limit splashing. Genuine vitreous china construction means a smooth surface which is non-absorbent and which withstands hard service.

Serving home and industry

AMERICAN-STANDARD • AMERICAN BLOWER • CHURCH SEATS • DETROIT LUBRICATOR • KEWANEE BOILER • ROSS HEATER • TONAWANDA IRON

MONEL LICKS ALL COMERS!



There are plenty of kayos credited to Monel*!

For more than 30 years, this rustproof Nickel Alloy has been the washroom champion. It has successfully met the corrosive attacks of tallow soaps and fluoride sours, laundry starches and dilute bleaches.

The latest challenge comes from synthetic detergents. Their efficiency on silks, woolens and rayons is pretty well known now, is becoming better known day by day.

Maybe you've wondered how these new detergents react in Monel equipment. Do they form hard-to-remove scum? Do they stain and discolor the metal?

The answer to both questions is "No!" Monel – fighting metal of the modern laundry – comes through every test with flying colors. That's the consensus of leading synthetic detergent manufacturers themselves. In the last few years when hundreds of laundrymen have been experimenting with synthetic detergents in their plants, not a single complaint has been registered with these manufacturers that any synthetic detergent has caused scum, corrosion or discoloration in Monel equipment. Fact is, many detergents are actually *manufactured* in Monel, pure nickel and Inconel equipment!

Yes, Monel licks all comers. And no wonder! It's solid metal—rustproof and corrosion-resistant through and through. And tests prove it's even stronger and tougher than structural steel!

Monel surfaces are hard and smooth. Years of continual use don't change them. They resist pitting, don't develop rough spots that snag and tear fabrics. Monel equipment lasts long, serves dependably. Through the years, it needs a minimum of inspection and maintenance. It helps you save labor, steam, power, water and other supplies.

That's MONEL – Champion in performance!

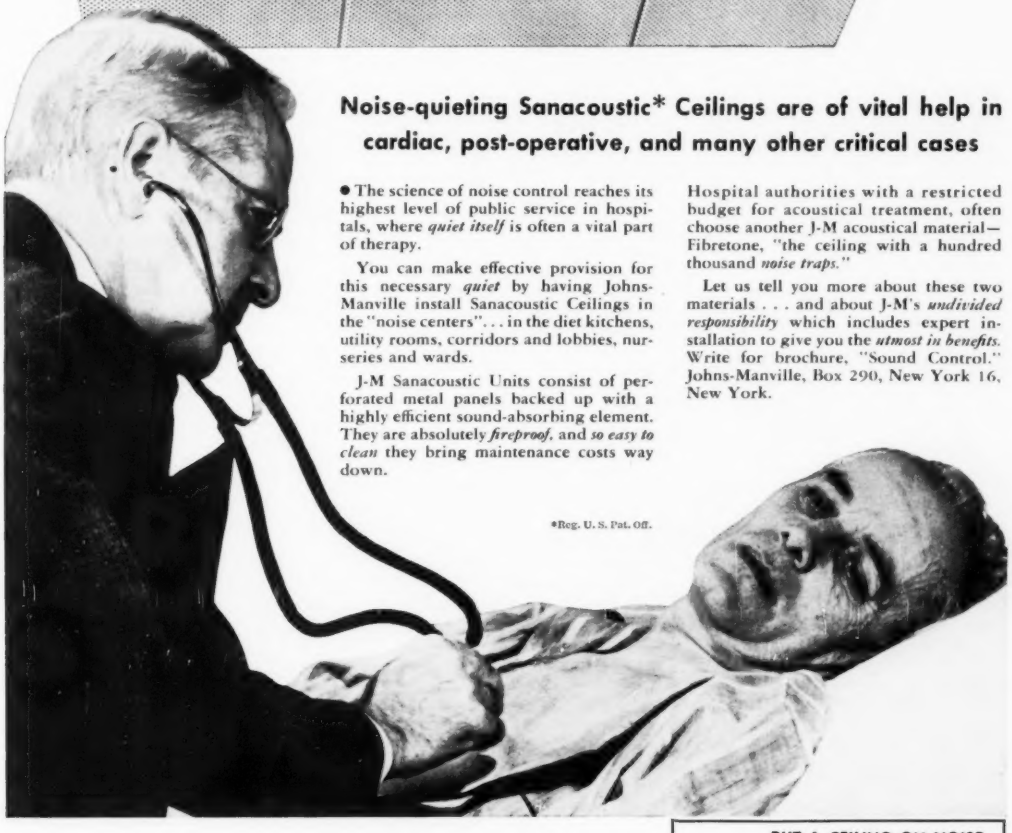
THE INTERNATIONAL NICKEL COMPANY, INC.
67 Wall Street, New York 5, N. Y.

*Reg. U. S. Pat. Off.

EMBLEM OF SERVICE
INCO
TRADE MARK

MODERN METAL FOR MODERN LAUNDRIES **MONEL*** **ALWAYS 100% NON-RUSTING**

When health itself depends on QUIET



Noise-quieting Sanacoustic* Ceilings are of vital help in cardiac, post-operative, and many other critical cases

● The science of noise control reaches its highest level of public service in hospitals, where *quiet itself* is often a vital part of therapy.

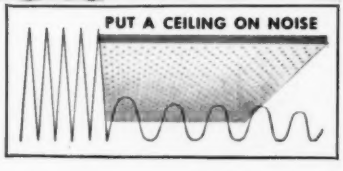
You can make effective provision for this necessary *quiet* by having Johns-Manville install Sanacoustic Ceilings in the "noise centers"... in the diet kitchens, utility rooms, corridors and lobbies, nurseries and wards.

J-M Sanacoustic Units consist of perforated metal panels backed up with a highly efficient sound-absorbing element. They are absolutely *fireproof*, and *so easy to clean* they bring maintenance costs way down.

Hospital authorities with a restricted budget for acoustical treatment, often choose another J-M acoustical material—Fibretone, "the ceiling with a hundred thousand *noise traps.*"

Let us tell you more about these two materials . . . and about J-M's *undivided responsibility* which includes expert installation to give you the *utmost in benefits.* Write for brochure, "Sound Control." Johns-Manville, Box 290, New York 16, New York.

*Reg. U. S. Pat. Off.



JOHNS-MANVILLE PRODUCTS

Johns-Manville

SANACOUSTIC CEILINGS

KENTUCKY BAPTIST HOSPITAL
Louisville, Kentucky
H. L. Dobbs, *Administrator*

This attractive 205-bed hospital, established in 1924, is owned by the Baptist Church of Kentucky. As is common with so many of the more than 1000 hospitals using FABRON today, it has employed FABRON as the decorative treatment throughout its Nurses' Home.

Thanks to FABRON, you no longer need to close rooms periodically for redecorating. No longer need you lose valuable room income. For FABRON overcomes the common causes of redecoration—assures uninterrupted use of rooms.

FABRON prevents plaster cracks from ruining the decoration! It strengthens plaster, hides blemishes, eliminates expensive repairs and ensuing redecoration.

FABRON prevents "staleness"! Ordinary soap and water maintenance keeps the sunfast lacquer colors free from dirt and grime.

FABRON won't crack or peel! Its lacquer colors are inseparably bonded to its sturdy backing of fabric and reinforcing plastic.

FABRON permits easy repairs! If gouged by equipment, it can be patched invisibly. No need to redecorate entire wall or room.

Yet FABRON is only slightly higher in cost than paint. But the savings it effects more than offset its premium within 2 or 3 years—the time when repainting of the rooms becomes necessary. Thereafter, FABRON's savings are cumulative, making it *the most inexpensive wall treatment obtainable.*

The FABRON collection offers more than 180 patterns and colors, styled to meet the requirements of every type of interior. Describe your next decorating or redecorating project and we will gladly send suggested samples and estimate of costs. Write today!

FREDERIC BLANK & CO., INC. *Est. 1913.* 230 Park Avenue, New York 17, N.Y.

FABRON *prevents fire-spread, too. Each roll bears the label of the Underwriters' Laboratories, Inc., sponsored by the National Board of Fire Underwriters.*

tested Underwriters' Laboratories, Inc. listed
National Board of Fire Underwriters

fabron

the fabric-plastic-lacquer wall covering for hospitals

Strength and durability considered,

CONCRETE JOIST CONSTRUCTION

Costs Less!

In these days of high costs, economy in building is important, provided strength and durability are not sacrificed. Here is where concrete joist construction comes in—since it provides rigid, strong, sound-proof buildings which are fire resistive, yet construction cost is lower. That is because the amount of concrete and, consequently, the dead load, are kept to a minimum for any span or live load. The concrete joist and monolithic top slab are formed with cores of removable Meyer steelforms, supported on skeleton centering. Once the concrete has set, the forms are removed and re-used from floor to floor and from job to job. Therefore, a nominal rental charge can be made for each use. Construction is speeded up.

WHY SPECIFY CECO?

Ceco originated the removable steelform method of concrete joist construction. The company is first in the field—actually providing more services than all competitors combined. So, when concrete joist construction fits your need, call on Ceco, the leader over all. Thirty-five years of experience in the field, on the job, have given Ceco a sure grasp of all concrete joist construction problems. This fund of knowledge is yours to command, in 23 strategically located offices from coast to coast.

CECO STEEL PRODUCTS CORPORATION

General Offices: 5701 W. 26th St., Chicago 50, Illinois

Offices, warehouses and fabricating plants in principal cities

Other Ceco Products Include—Reinforcing Steel, Welded Wire Fabric, Steel Joists and Roof Deck, Metal Windows and Doors, Metal Frame Screens, Aluminum Storm Windows, Metal Lath and Accessories

CECO STEEL

In construction products **CECO ENGINEERING** *makes the big difference*

Today it's Latex Foam Rubber!

for Comfort and Cleanliness . . .

For mattresses, cushions, operating table pads, ambulance mattresses and similar hospital requirements there's nothing to compare with PerfeKtum Latex Foam Rubber (Airfoam*).

Latex foam rubber does not become flat, hard, saggy or lumpy. It's dustless, non-toxic and inhibitive to bacterial growths. It repels germs, moths and vermin and is easily washed with soap and water, and sterilized by sponging and spraying.

Learn more about how this amazing ***long-wearing*** material can cut your costs and provide greater comfort for your patients. Write today for our newest leaflet which describes in detail the many advantages of PerfeKtum Latex Foam Rubber (Airfoam*) mattresses, cushions and hospital specialties.

*T.M. The Goodyear Tire & Rubber Co.

PerfeKtum Products Co.

300 FOURTH AVE. *Established 1922* **NEW YORK 10**

Where Does It Go?

Solve the problem of allocation and identification of linens, equipment and wearables—mark them with Cash's Woven Names. With an eye on lower replacement costs and efficient management, hospitals use Cash's Names to identify sheets, towels, blankets, etc., by ward and department—eliminate unnecessary loss and misuse of uniforms and other wearables.

Cash's Names are economical, permanent—the name is WOVEN into the tape; won't run or fade; last as long as the articles they mark; sanitary because they stand boiling. And they're easy to attach with thread or Cash's NO-SO Boilproof Cement (25c a tube).

Ask your Dept Store or write us your requirements

Personal Name Prices

12 doz. $3.50 — 9 doz. $3.00
6 doz. 2.40 — 3 doz. 1.80

Cash's

WOVEN NAMES

So. Norwalk 12, Conn.
or
6208 So. Gramercy Pl., Los Angeles 44, Calif.

Brighter Floors with

DOLCOWAX

Compare distinctive milky DOLCOWAX with the usual dark gray floor wax emulsion. That sparkling lightness is preserved from laboratory test tube to your floor—the result of precise blending of the finest ingredients obtainable including the top grades of carnauba wax.

DOLCOWAX spreads and levels well . . . forms a hard, clear coating on all standard types of flooring which grows brighter as it is polished by traffic. It preserves flooring . . . helps lengthen the life of expensive linoleum, cork, rubber and mastic.

Write for complete illustrated booklet "Floor Maintenance"

The C. B. DOLGE CO.

WESTPORT, CONNECTICUT

Pardon our modesty . . .

BUT . . .

1 Wilson Soda Lime, U. S. P., has been a medical standard for 28 years.

2 Hospitals use *three times as much** Wilson Soda Lime as all other CO_2 absorbents combined.

3 Tests† show that, pound for pound, Wilson Soda Lime *absorbs more* CO_2 than any other CO_2 absorbent used for medical purposes.

4 No wonder, dollar for dollar, Wilson Soda Lime gives the *highest* value at the *lowest* cost.

"Research-designed to make it the best
Research-studied to keep it the best"

IMMEDIATELY AVAILABLE FROM YOUR LOCAL SUPPLIER

GENUINE

WILSON SODA LIME

reg. u. s. pat. off.

* Recent surveys showed that Wilson Soda Lime is used 7 to 1 over any other CO_2 absorbent

† Laboratory tests supplied upon request.

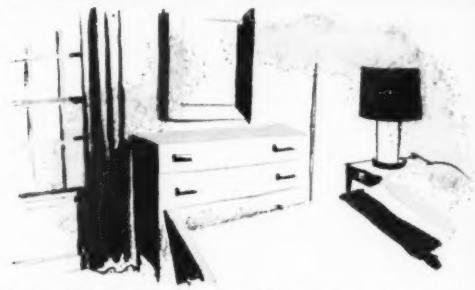
A Product of **DEWEY AND ALMY CHEMICAL COMPANY**

CAMBRIDGE 40, MASSACHUSETTS

Here's how to solve all your hospital's cleaning problems!

From the lobby—Hospitals must be spotless from the lobby to the "labs." Keep your lobby and waiting rooms clean and inviting by using LIQUID SCRUB SOAP on your linoleum, terrazzo and marble surfaces. And for your washrooms—use LIGHTHOUSE CLEANSER and LIGHTHOUSE WASHING POWDER.

Along the corridors—Along the long, busy hospital corridors, there are many cleaning problems. To keep the corridors shining, use HOSPITAL GREEN SOAP. Put FORMULA NO. 99 ANTISEPTIC SOAP in the operating room for surgical scrub up. (Remember Armour's GLYCERINE in the hospital pharmacy.)



To the patient's room—To keep the patient's room light and bright there's: REGAL DETERGENT for the mirrors and windows—NO. 422 SYNTHETIC DETERGENT for the walls—ROYAL FLAKES for the blankets and bedspreads. And put a bar of CLIPPER in every room for the patient's own use.

And from the kitchen—To help maintain the high sanitary standards of your kitchen, there's LIGHTHOUSE WASHING POWDER. To lighten the work of your kitchen staff there's NO. 422 SYNTHETIC DETERGENT—and for spotless ranges, pots and pans, there's LIGHTHOUSE CLEANSER and TOPAZ CHIPS.

To the laundry—Your laundry, too, has high standards of cleanliness to maintain. To keep your linens really white, use FLINT CHIPS. And there's HILO POWDER for your colored work. For your heavy laundry work, try GIANT POWDER, the ready-built soap made to stand up under high temperatures.

There's an Armour soap for every cleaning problem in your hospital

ARMOUR

Industrial Soap Division

ARMOUR AND COMPANY
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NATIONAL SURVEY BY
INDEPENDENT ORGANIZATION
REVEALS THAT—
for patients' special diets and with
meals, hospitals serve
CANADA DRY GINGER ALE
more often than
any other carbonated beverage.
PURE—produced under rigid scientific controls which insure utmost purity and uniformity.
WHOLESOME—Canada Dry contains only the finest ingredients . . . water that is scientifically treated and multiple-filtered; choicest Jamaica ginger; pure sugar.
DELICIOUS—Canada Dry is the world's finest Ginger Ale—a cooling, refreshing beverage for any occasion.
CANADA WORLD FAMOUS DRY
GINGER ALE
CANADA DRY

Steaks

that melt in the mouth ...from meat you buy for less

This is the model 700 U. S. Tendersteak Delicator—designed and engineered by food machine specialists to give you the quickest, slickest way of making taste-tempting steaks, steaklets and other specialties.

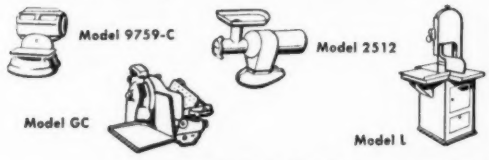
Restaurant operators who are using this machine tell us it pays for itself every month—in increased trade and the sale of high-profit dishes. Chefs like it, too—because it saves their time, and gives them an easy way to vary their menus.

Tenderizes, in *five seconds.* Pierces tough sinews without bruising. Knits together small pieces or different kinds of meat and other ingredients. Assures you years of trouble-free, satisfying service. For full information, on this or any other U. S. food machine, fill out coupon, mail today.

FREE!

FOOD COST CONTROL CARD—
Helps you regulate slicing thickness for meat, cheese, vegetables and bread, so that you make more profit per portion.

Quality Food Machines



"BERKEL" "TENDERSTEAK DELICATOR" REG. U. S. PAT. OFF.

U. S. SLICING MACHINE COMPANY, INC.
La Porte, Indiana

U. S. Slicing Machine Company, Inc.
Dept. MH.
La Porte, Ind.

Please send my free "Food Cost Control Card"—also full information on U.S. Tendersteak Delicators ☐ Slicers ☐ Choppers ☐

Name.....

Street.....

City..... State.....

New, easier-to-cook MALEKIZED* RICE always looks like this!

*TRADE MARK

WRITE ON YOUR LETTER-HEAD FOR FREE SAMPLE

WALTON'S MALEKIZED WondeRice
Produced Under License by
Walton Rice Mill, Inc.
Stuttgart, Arkansas

Malekized
GENERAL AMERICAN

MALEKIZED RICE PROCESS
GENERAL AMERICAN TRANSPORTATION CORPORATION
135 South LaSalle Street • Chicago 90, Illinois

These unretouched photographs show rice that has been MALEKIZED—rice kernels that are distinct and separate, firm, yet fluffy—appetizing to look at, nourishing to eat.

MALEKIZED rice is better rice—easier to cook in large batches. Never gummy or messy, MALEKIZED rice *can't* stick to the pot as long as the water isn't boiled away. The kernels will not stick together. No draining, washing, steaming or stirring! Even inexperienced kitchen help can prepare MALEKIZED rice easily.

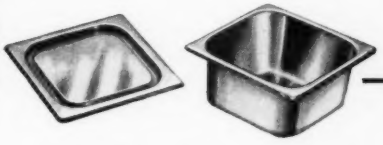
It tastes better, too—has a delicate, distinctive flavor that goes well with almost anything on your menus.

By United States Army Quartermaster nutrition tests, MALEKIZED rice has more than *twice* the vitamin content of ordinary rice.

The MALEKIZING process was developed and perfected by General American food experts and engineers. Malekizing equipment fits into all standard milling operations and can be installed, operated and maintained economically.

Labor-Saving Convenience for the Staff...

Valuable Dietary Benefits for the Patients!



Ideal Food Conveyors are available in many different models meeting every food service requirement and budget need. Many exclusive, patented design and construction features. Write for catalog.

THIS NEW *Ideal* SPECIAL DIET TRAY recently

introduced to hospital dietitians received an immediate and enthusiastic reception.

Enlarged production facilities now enable us for the first time to fill orders promptly. The Ideal Diet Trays now in production embody worthwhile improvements suggested by dietitians and users.

The dishes are made with square corners to provide greater capacity.

The edges are extended to form handles facilitating removal of the dish.

The Ideal Diet Tray contains 6 removable food receptacles mounted in a strong metal rack. The entire assembled unit is interchangeable with meat tray in all Ideal Food Conveyors. The receptacles are 5½"x5½"x2½" deep providing 1¾ qt. capacity each.

Individual covers are supplied at no extra cost, if desired. All receptacles are interchangeable. All nest for storage.

Send in your order.

THE SWARTZBAUGH MFG. CO. Established in 1884 • Toledo 6, Ohio

Distributed by The Colson Corp. Elyria, O. • The Colson Equipment and Supply Co., Los Angeles and San Francisco • In Canada: Canadian Fairbanks-Morse Co.

Ideal
FOOD CONVEYOR SYSTEMS
Found in Foremost Hospitals

3 REASONS WHY

C.P.P. Toilet Soaps are No. 1 choice of Hospitals!

This Hospital Superintendent Advises:

"Throughout my years of hospital experience, I've found there's a C.P.P. soap that pleases every patient. And it's bound to be a pure, mild product that meets highest hospital standards.

"Palmolive, for instance, is popular with patients and nurses alike. Men enjoy its refreshing fragrance—and so many women seem to follow the 14-Day Palmolive Beauty Plan."

This Nurse Reports:

"Patients brighten up when they find that their favorite Colgate-Palmolive-Peet soap is waiting for them. It's only natural that they prefer the soaps they use in their own homes.

"Cashmere Bouquet Toilet Soap is a big favorite in private pavilions. Women like its delicate perfume, its hard-milled texture. Really, it's such a luxury for so little more."

This Purchasing Agent Says:

"When younger purchasing agents ask my advice, I always suggest that they consider Colgate-Palmolive-Peet soap products. For I've found C.P.P. always meets hospital requirements.

"Why, Colgate's Floating Soap is made *especially* for hospital use. Meets the most exacting requirements for purity, mildness, man-sized lather. And comes in a wide range of sizes, too."

All 3 Agree on C.P.P.

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An analoque of medicine you may never have thought of

As every doctor knows, medicine is the art of ministering to the sick and keeping the well in good health.

But it is the professional societies throughout the land who most often give reality to this definition.

For through them medical research and advances come into clinical channels. In these channels this newer knowledge becomes effective on patients.

There is an analogous situation in the food-processing industries, especially the canning industry.

For, as you know, canning is simply the process of heating foods to destroy spoilage organisms and of putting them in airtight containers to preserve them.

But this is merely a *definition* of canning.

To give it reality and meaning throughout the land there is a "society," if you like, which performs a function similar to that of the professional societies.

This "society" is called the "Processing Committee of the National Canners Association."

This committee is the channel through which every bit of research and advance in food processing is brought to the attention of the individual food packer.

What is the result? Canned foods today have a quality, nutritive value, and freedom from pathogenic organisms of the highest order.

Here is a reality worthy of your highest confidence.

American Can Company

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The Seal of Acceptance denotes that the statements pertaining to nutrition in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

Serve "That Second Cup" Piping Hot

From a Genuine STANLEY COFFEE SERVER

It may seem a small detail... but not to your patients and your dietitian. When coffee and tea are served really hot, *especially the second cup,* your dietitian knows that most complaints about food are eliminated. Even with unavoidable delays between kitchen and bedside, thoroughly-insulated STANLEY SERVERS deliver beverages appetizingly hot . . . keep the very last drop hot, too.

STANLEY
"THEY WILL NOT BREAK!"

THE CHOICE BECAUSE

Here's why STANLEY SERVERS are standard equipment today in many of the nation's largest, best equipped hospitals.

EFFICIENCY—By test, STANLEY SERVERS keep coffee 20° hotter at the end of 2 hours than do ordinary pots. Hold temperatures—hot or cold—efficiently.

CLEANLINESS—Nickel-silver shells, stainless steel linings and wide mouths make them easy to sterilize and keep clean. All seams are air-tight, water-tight.

ECONOMY—Pay for themselves in reduced replacement. Break-proof, chip-proof, crack-proof. Extra-durable shells and hard-soldered hinges. No costly repair of spouts or handle insulators.

EASY UPKEEP—Stainless steel linings do not require replating, constant polishing. No spout cleaning problem.

FLAVOR—Get coffee to patients in better condition. Seal in aroma. Stainless steel linings eliminate metallic taste.

APPEARANCE—Add note of luxury to the little refinements that differentiate between ward and private room service.

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Waldorf-Astoria Style also available
10-oz. and 20-oz. Capacity
Etched with crest or name at slight additional cost

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DIXIE PAPER SERVICE cuts meal costs

Many hospitals are lowering costs by using paper service at bedside, for between-meal feedings, in staff dining rooms. Paper requires no dishwashing—no soaps, detergents, sterilizing. Breakage is saved, food waste reduced through stricter portion control. Handy, always-ready Dixie Cups and Containers save time, labor and materials—besides maintaining the cleanliness essential to a well-run institution.

For food and drink service that's

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QUIETER
SMOOTHER
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Smooth to the Lips
Pleasant to Touch
Rigid Construction
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most widely advertised
. . . most popular of paper cups

"Dixie" is a registered trade mark of the Dixie Cup Company

For complete information on paper service, write Dixie Cup Co., Easton, Pa.

DIXIE CUPS, VORTEX CUPS AND PAC-KUP CONTAINERS ARE MADE AT EASTON, PA., CHICAGO, ILL., DARLINGTON, S.C., FT. SMITH, ARK., TORONTO, CANADA

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in any weather...
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Rusco All Metal, Self-storing Combination Screen and Storm Sash offer positive, safe ventilation. In warm weather, just raise the Magic Panel to full ventilating position. In cold weather, lower it for complete storm window protection. Rainproof, draft-free, filtered screen ventilation is secured by a simple fingertip adjustment from inside.

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Designed for the Hospital!

. . . with emphasis on ECONOMY, CLEANLINESS, DURABILITY

THE WALLACE SILVERSMITHS have made an exhaustive study of the *special* holloware requirements of hospitals for patient food service. Today, as a result of this study, a holloware service has been developed that takes into consideration all of the "musts" attendant on this important phase of hospital management. They are:

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For further details, consult your Wallace Supply Dealer, or write to . . .

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Surgical Risk

AND THE ELDERLY PATIENT

Surgical risk mounts rapidly in the late decades of life.[1] A frequent complicating condition in surgery of the aged is malnutrition, the result of poor dietary habits and of dietary deficiencies. For the elderly patient, clinical observations point to the wisdom of dietaries high in protein, minerals, and vitamins, moderate in carbohydrate, and low in fat. The best possible state of nutrition is emphatically the best preparation of the aged patient for surgery.

Ovaltine in milk, a *multiple* dietary supplement, is especially useful for rectifying faulty diets common with elderly patients. Its pleasing flavor leads to its ready acceptance even in the lessened taste acuity of old age. Its richness in multiple vitamins and minerals and biologically complete protein, in particular, are advantageous in the diet of the aged. Another notable feature is its easy digestibility.

The valuable amounts of multiple nutrients provided by three daily glassfuls of Ovaltine in milk, are tabulated below.

[1]Martin, J. D., Jr.: Surgical Risk in the Elderly Patient, Geriatrics 3:296 (Sept.-Oct.) 1948.

THE WANDER COMPANY, 360 N. MICHIGAN AVE., CHICAGO 1, ILL.

Ovaltine

Three servings daily of Ovaltine, each made of ½ oz. of Ovaltine and 8 oz. of whole milk,* provide:

CALORIES	676	VITAMIN A	3000 I.U.
PROTEIN	32 Gm.	VITAMIN B_1	1.16 mg.
FAT	32 Gm.	RIBOFLAVIN	2.0 mg.
CARBOHYDRATE	65 Gm.	NIACIN	6.8 mg.
CALCIUM	1.12 Gm.	VITAMIN C	30.0 mg.
PHOSPHORUS	0.94 Gm.	VITAMIN D	417 I.U.
IRON	12 mg.	COPPER	0.5 mg.

***Based on average reported values for milk.**

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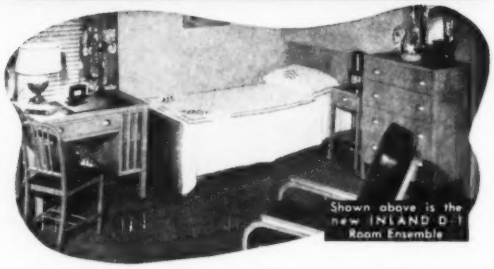

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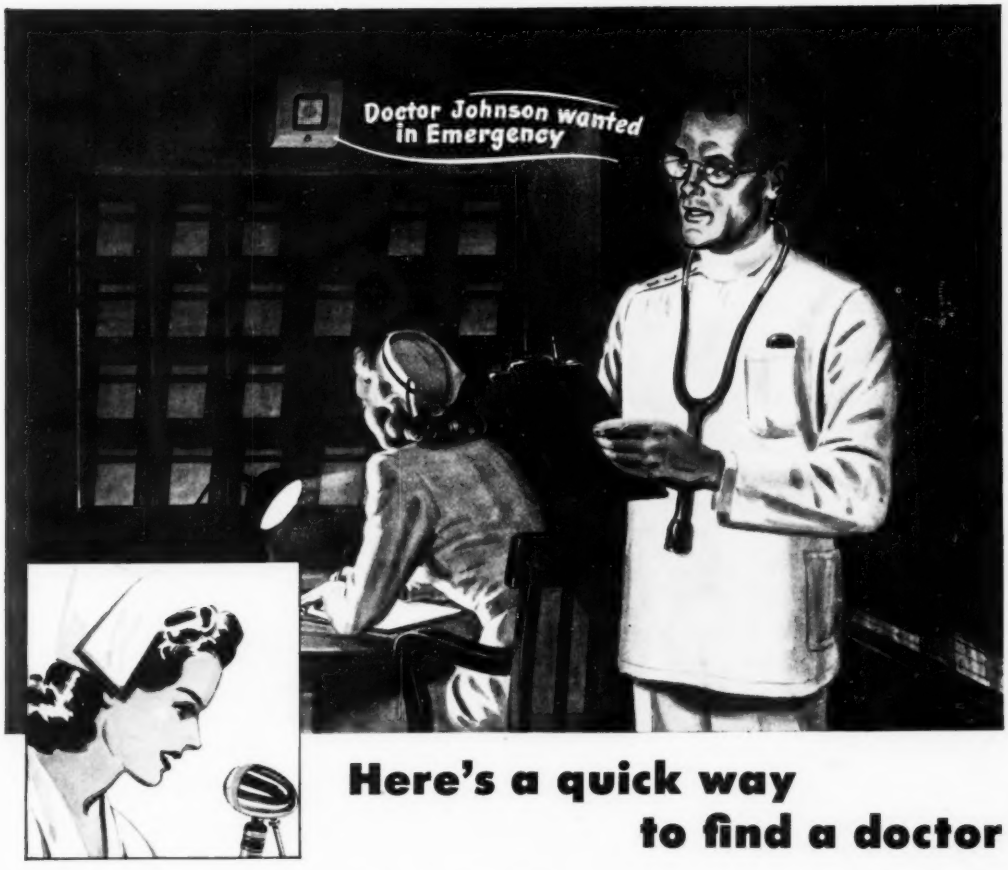

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Goodall Fabrics are *Blended-for-Performance* to keep your maintenance costs low

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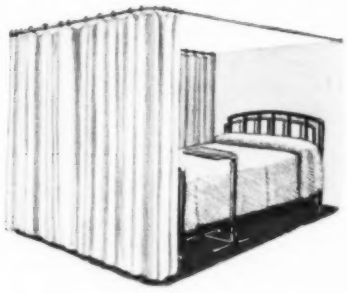

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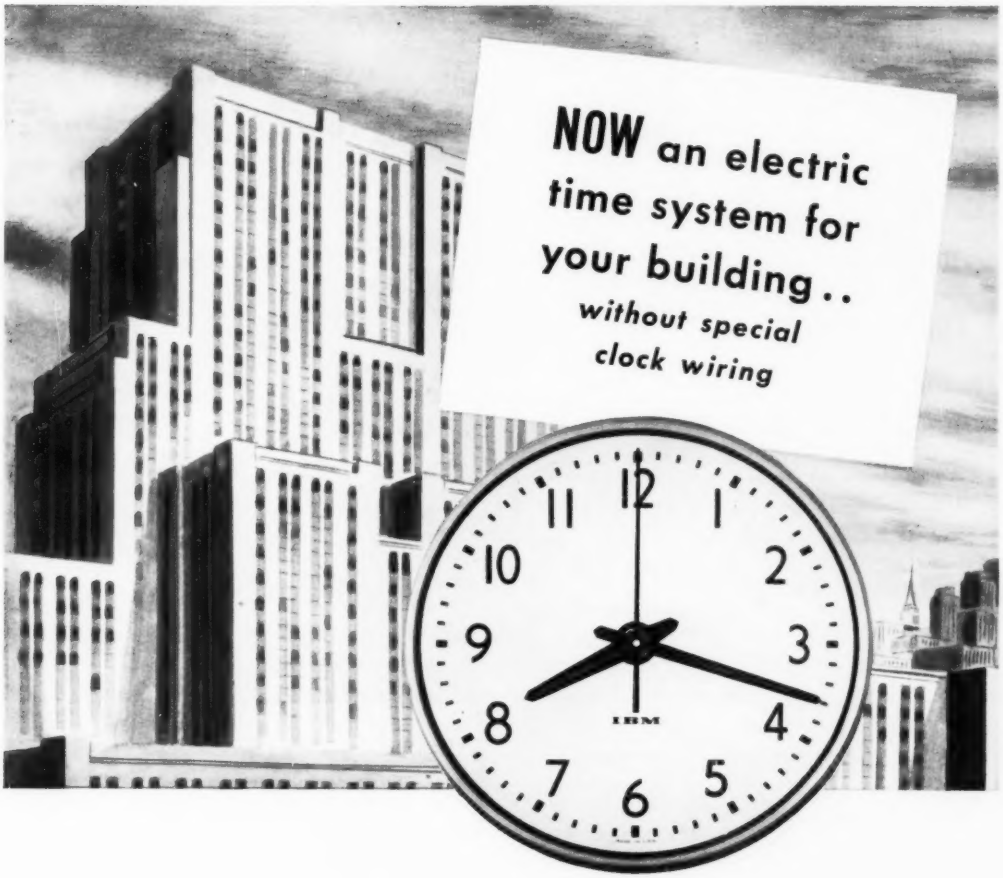

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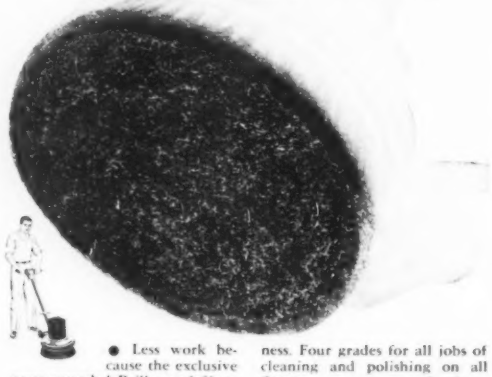

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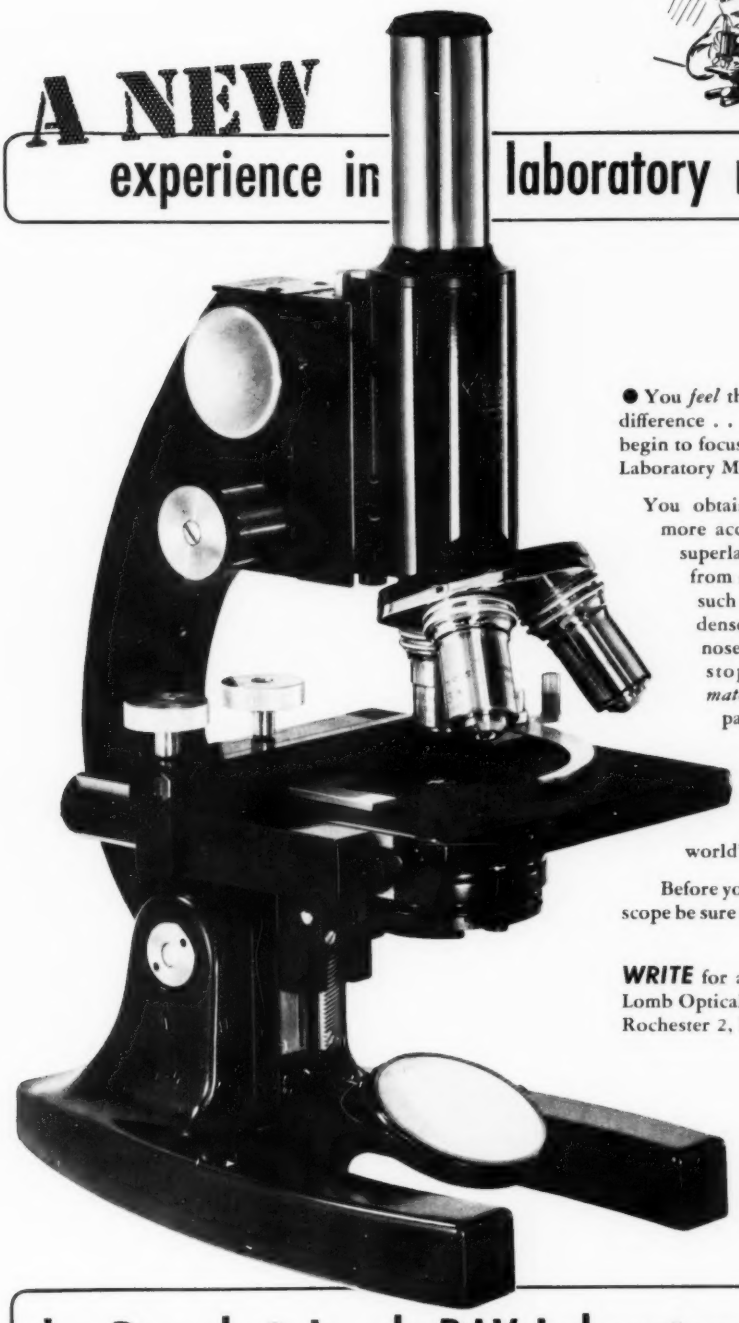

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You obtain proper adjustment faster, more accurately, with less effort . . . superlative performance resulting from advanced mechanical features such as the variable focus condenser, threadless cell lens mounts, nosepiece with roller bearing stop, coarse adjustment with *matched* rack and pinion, and patented lever fine adjustment.

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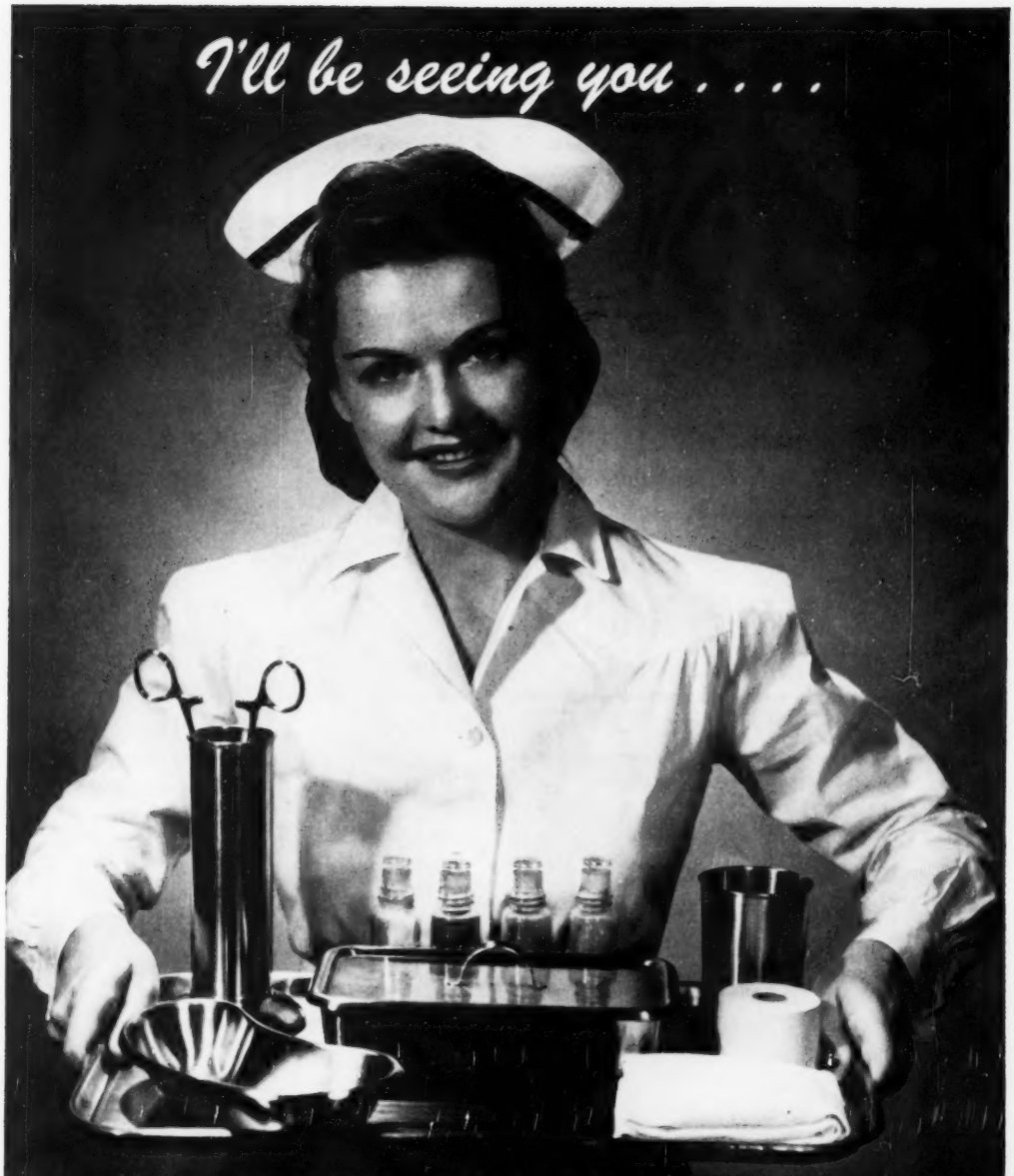

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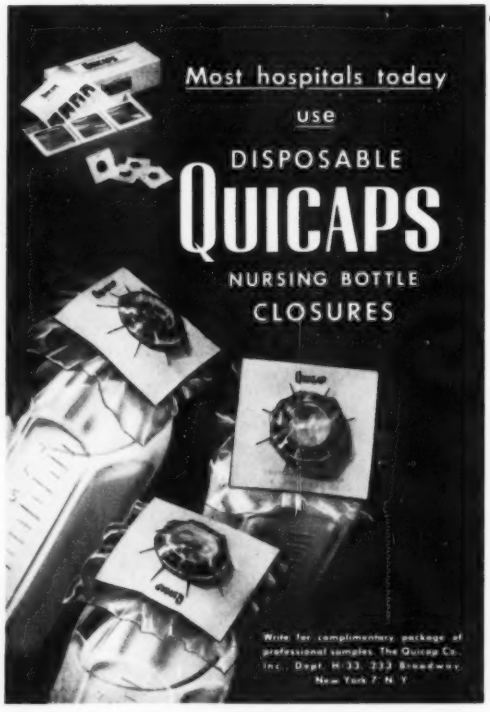

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Nurses' uniforms with the patented Flexsleev feature please the wearer by eliminating tug and strain, improving durability and appearance. And they please administrators — as do all Marvin-Neitzel products — by improving hospital appearance and morale.

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And remember, only pre-tested fabrics are used by Marvin-Neitzel.

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- Non-irritant
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- Non-corrosive
- Economical
- Pleasant odor

For disinfecting floors, walls, furniture, bedding. Won't fade or discolor.

O-syl is a significant and important development in the field of disinfectants. A non-irritating, non-caustic, non-specific germicide, O-syl successfully and promptly attacks the many pathogenic bacteria and fungi whose elimination is the object of disinfection and antisepsis.

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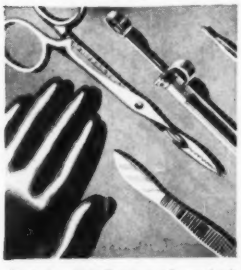
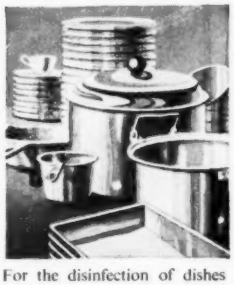
No disagreeable odor lingers after disinfecting with O-syl, because O-syl is nearly odorless—unlike many familiar disinfectants in hospital use.



For the disinfection of surgical instruments and rubber goods.

For preparing the obstetric patient.

For ringworm of the foot to disinfect socks, stockings and as a foot bath.



For the disinfection of dishes used by patients with contagious diseases.

For the hands as an antiseptic rinse. Doesn't burn or irritate.

O-syl diluted 100 times makes an economical, potent disinfectant solution for general use—costing as little as 2.4¢ per gallon.

O-SYL (HOSPITAL STRENGTH, PHENOL COEFFICIENT 5) IS LISTED AT $3.00 PER GALLON IN GLASS CONTAINERS.

5% discount for shipment in individual 5-gal. drums. 10% discount for shipment in individual 10-gal. drums. 20% discount for shipment in individual 50-gal. drums. Freight prepaid on 10 or more gallons shipped at one time to one address. Terms 2% 10 days, 30 days net.

O-syl

REG. U. S. PAT. OFF.

Call your hospital supply dealer today or write direct to Lehn and Fink Products Corp., Hospital Dept., 445 Park Ave., New York 22, N. Y. Professional Sample on Request.

NONE FINER MADE!

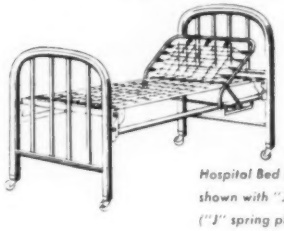
FOSTER *Ideal*

HOSPITAL SLEEP EQUIPMENT FOR EVERY REQUIREMENT

Pictured bed is Foster #851-3 Hospital Model. This bed shows #3 Crank Adjustable Spring, #10 Adjustable Bedsides that fit either side, and special Hospital Innerspring Mattress. Irrigator Rod shown can be readily placed at head or foot of bed or easily changed from one bed to another. #851 Bed Ends are 1¾ in. Victorian, electric welded tubing. Inside length between posts, 6 ft. 7 in. Stock finish, grained walnut. Comes equipped with 3 in. rubber composition casters. Shipping Weight – 250 lbs. complete as shown.

"A DEPENDABLE SOURCE OF BEDDING PRODUCTS SINCE 1871"

Hospital Bed Ends #851 shown with "J" flat link spring.



Hospital Bed Ends #851 shown with "JB" spring ("J" spring plus backrest)

Write for new catalog #149 showing complete Foster hospital line.

SEE OUR PERMANENT DISPLAY ONE PARK AVE., N. Y. 16, N. Y.

FOSTER BROS. MFG. CO.

UTICA, N. Y. ST. LOUIS, MO.

U.S.P. Oxygen

—and that's *not all!*

▶ For inseparable from LINDE oxygen U.S.P. are the years of LINDE research in oxygen therapy techniques, LINDE's engineering experience, and the years of medical research carried out with LINDE's co-operation.

And, inseparable also is LINDE'S policy of service to all users. That is why you see pictured here literature, motion pictures, engineering help, and technical aid. All are part of LINDE'S continuing program toward safer, more effective, and more economical oxygen administration.

THE LINDE AIR PRODUCTS COMPANY
Unit of Union Carbide and Carbon Corporation
30 East 42nd Street UCC New York 17, N. Y.
Offices in Other Principal Cities
In Canada: Dominion Oxygen Company, Limited, Toronto

The term "Linde" is a trade-mark of The Linde Air Products Company

for INTRA-MEDULLARY NAILING in *Traumatic Surgery*

CROSS SECTION
(Actual Size)

Intra-Medullary nailing is an important innovation in traumatic surgery. With careful selection of cases and proper technique it is considered by many Orthopedic Surgeons as superior to all previous methods for the treatment of fresh closed fractures, especially those of the femur.

Zimmer Manufacturing Company has worked toward the elimination of complications which sometimes resulted from former methods. It has developed the new Küntscher Cloverleaf pattern femur pin and the necessary instruments for its use.

Clinical tests were arranged at one of the leading Orthopedic Clinics of the United States. An operation using the pins and instruments was televised by prominent surgeons before an interested group representing the American College of Surgeons.

Zimmer Quality, of Course

The material in these pins is a Special S.M.O. Stainless Steel adopted by the Bureau of Standards for internal fixation devices. The standard sizes are 7, 8, 9, 10 and 11 mm diameters and 36 cm to 52 cm lengths. The cloverleaf pattern provides great strain and stress strength and the displacement of material in the medullary canal is minimal.

The special instruments for use with this pin are Pin Guide, Reamer, Driver, Pin Set and Extractor.

These instruments have been given the same serious study and consideration as the femur pin itself. They have been tested under clinical use, and where necessary, corrections were completed to provide a minimum set which would conform to actual conditions anticipated.

Write for Descriptive Literature and Prices

Zimmer
MANUFACTURING CO., WARSAW, IND.

Which is more resistant to common infant skin irritants

. . . the **continuous** film of Mennen Antiseptic Baby **oil**?

. . . the **discontinuous** film of a baby **lotion**?

Recent tests by a leading independent research chemist[1] compare Mennen Antiseptic Baby Oil and a commercially manufactured baby lotion as to their penetrability by common infant skin irritants.

These tests utilized a method originally devised by Schwartz, Mason and Albritton[2] for the evaluation of protective ointments. Film layers as thin as 0.07 mm were achieved, to approximate as closely as possible oil film on infant skin.

The results of these tests, as reported in a leading medical journal[1], indicate:

1. Mennen Antiseptic Baby Oil was impenetrable for periods of *at least three hours* to these common infant skin irritants: acidic, alkaline, and ammoniacal urine; acidic suspension of feces and aqueous solutions of acid and alkaline reaction.

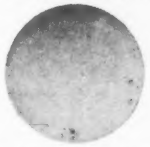
2. The baby lotion, however, was universally penetrated by all these irritants within *60 seconds*. (The film formed by the baby lotion established an aqueous phase between its upper and lower boundary, thus permitting immediate and facile penetration of the solutions tested).

The findings also report:

Mennen Antiseptic Baby Oil: "The film of the baby oil . . . is homogeneous in appearance except for occasional blemishes due to isolated dust particles."

Baby lotion: "Pictures of the oil-in-water emulsion show numerous jagged particles . . . presumably traces of the stabilizing agent and other crystalline ingredients left after evaporation of the aqueous phase."

ELECTRON MICROPHOTOGRAPHS CONFIRM FINDINGS OF PENETRABILITY TESTS



Film of Mennen Antiseptic Baby Oil (0.21 mm), 20,000 X. *Note homogeneous character.*

Film of evaporated baby lotion (0.21 mm), 20,000 X. *Note breaks, irregularity.*

More than 3400 hospitals—the majority of those important in maternity work—use Mennen Antiseptic Baby Oil routinely in the nursery.

mennen antiseptic baby oil
provides continuous film to help protect better

1. Elsner, H. — "A Method for the Study of the Penetrability of Liquid and Semi-solid Films Used in Skin Protection". Journal of Investigative Dermatology. Vol. 10, No. 4, April, 1948. *Reprints upon request.*

2. Schwartz, L., Mason, H. S., and Albritton, H. R.—"A Method for the Evaluation of Protective Ointments". Occupational Medicine 1:376-385 (April) 1946.

Hospitals approve Ivory's "bedside manner"

Like an experienced doctor or nurse, Ivory Soap has the perfect bedside manner. It has qualities which contribute to the comfort of bed weary patients. It's business-like, but gentle. It has no useless frills. It inspires confidence.

Small wonder that Ivory has itself become an "institution" in so many, many institutions dedicated to the healing of the sick. Small wonder that *more doctors advise Ivory Soap* than all other brands put together.

99 44/100% pure - it floats

Pure, mild, rich lathering Ivory Soap is available for hospital use in a choice of 5 convenient sizes. First choice in the big majority of hospitals is the generous, unwrapped 3-ounce size.

Procter & Gamble

WANT ADVERTISEMENTS

POSITIONS WANTED

ANESTHETIST—With fifteen years' experience all types anesthesia; given over several thousand cases curare, sodium pentothal; salary and commission. MW 27, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

DIRECTOR OF NURSES—Single, protestant; B.S., M.A. in Nursing Education and Administration, experience in administration of nursing schools and nursing services. MW 33, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

HOSPITAL MANAGER—Successful hotelman, administrator and food expert seeks connection with large, prominent New York hospital, as resident manager, where past experience can be used to advantage; able to handle large staff, public and employee relations, purchasing and building maintenance; fine personality, able to get along in organization; hard worker and resourceful; finest references. For information Carl Letsch, Ronkonkoma, Long Island. Tel. 8745.

HOUSEKEEPER—Energetic, experienced, desires affiliation with 400-500 bed hospital. MW 32, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

PERSONNEL EXECUTIVE—B.S., M.A., experienced in all phases of management desires challenging position requiring organizing ability and leadership; $6500 per year; Washington or New York preferred; available in 60 days. MW 28, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

MEDICAL PHOTOGRAPHER—15 years' experience including color, wants position as head of department in hospital, south or southwest preferred. MW 35, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

REGISTERED NURSE—Seeks appointment as assistant to the medical record librarian or position in the hospital admitting office. MW 31, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

SURGEON—For your community hospital; American, protestant, age 51, experience in private practice, Army, and as chief of 65-bed government hospital; now in surgical residency; available July 1st. MW 29, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

INTERSTATE HOSPITAL AND PERSONNEL BUREAU
Miss Elsie Dey, Director
332 Bulkley Building
Cleveland, Ohio

ASSISTANT BUSINESS MANAGER—College graduate; accounting experience; 5 years, M.A.C.; 3 years, business manager and purchasing agent, 325-bed tuberculosis hospital, midwest.

ADMINISTRATOR—Degree, Business Administration; courses, Hospital Administration, University of Chicago; 5 years, assistant director, 500-bed hospital, midwest; 4 years, 350-bed hospital; experience in equipping new buildings.

INTERSTATE—*Continued*

MEDICAL DIRECTOR—Or administrator; exceptionally good experience, as director of large county and teaching hospitals, south and east; good financier; well recommended; available March.

SUPERINTENDENT—R.N.; age 44; 10 years' experience; capable; tactful; fine business ability; prefers 150-bed hospital, with or without school.

THE MEDICAL BUREAU
Burneice Larson, Director
Palmolive Building
Chicago 11, Illinois

ADMINISTRATOR Lay: B.S., Education, Master's, Business Administration; five years, assistant director, teaching hospital; four years, administrator, 300-bed hospital; FACHA.

ADMINISTRATOR—Assistantship, or directorship, small hospital preferred; Master's in Hospital Administration; year's administrative internship; year's assistantship.

ADMINISTRATOR Medical: FACHA; has had experience as administrator in voluntary and public hospitals; recognized as leader.

ADMINISTRATOR Graduate nurse: B.S., Columbia; graduate collegiate school; year's training in Hospital Administration; four years, assistant administrator, 300-bed hospital.

ANESTHESIOLOGIST—Diplomate, American Board of Anesthesiology; several years' private practice of anesthesiology; prefers directorship, hospital department.

PATHOLOGIST—Diplomate; past five years, professor of pathology, university medical school, and director of laboratories, teaching hospital; in thirties.

RADIOLOGIST—Diplomate, American Board; four years, assistant radiologist, large teaching hospital; seven years, director, radiology, 250-bed hospital.

MEDICAL DIRECTOR—Tuberculosis specialist; degrees, leading schools; since 1940, medical director, 175-bed sanatorium.

PUBLIC RELATIONS DIRECTOR—A.B., A.M., middle western university; eight years, director, public relations, division of national health organization.

WOODWARD MEDICAL BUREAU
(Formerly Aznoe's)
Ann Woodward, Director
185 North Wabash Avenue
Chicago 1, Illinois

RADIOLOGIST—Age 31, graduate midwestern university medical school, English-Swiss-catholic, with four years' training in radiology seeks hospital appointment of assistantship; eligible for the American Board with three years credit to date. Please inquire Ann Woodward, Woodward Medical Personnel Bureau, 185 North Wabash, Chicago.

(Continued on page 214)

WOODWARD—*Continued*

PATHOLOGIST—Age 32, English, episcopalian, graduate eastern medical school; four year residency training; formal training completed for American Board; member College of American Pathologists; available July 1; asking $10,000. Please inquire Ann Woodward, Woodward Medical Personnel Bureau, 185 North Wabash, Chicago.

POSITIONS OPEN

ANESTHETIST—Nurse anesthetist wanted for 150-bed hospital. Apply to: Mother Marie, Administrator, Maryview Hospital, Portsmouth, Virginia.

ASSISTANT DIRECTOR OF NURSES—Night Supervisor, Instructor, operating room Nurses; Missouri Baptist Hospital. Apply, Ella M. Gerhold, R.N., Director of Nurses, St. Louis, Missouri.

BACTERIOLOGIST AND CHEMIST—Experienced, wanted for city public health laboratory; must have at least B.S. Degree; salary $3900 yearly. Apply Dr. F. A. Musacchio, City Health Department, City Hall, Hammond, Indiana.

CHIEF DIETITIAN—Wanted for 200-bed tuberculosis hospital; attractive salary, plus room, board and laundry; send photograph, state qualifications and personal details. Apply Superintendent, Indiana State Sanatorium, Rockville, Indiana.

CLINICAL INSTRUCTORS and SUPERVISORS—Qualified to promote new clinical teaching programs in medical, surgical and pediatric departments in a 265-bed general hospital with a school of nursing; hospital located twenty minutes from Times Square within easy commuting distance to New York and Columbia University; salaries open. MO 31, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

DIETITIAN—(Member of ADA) to have full charge of dietary department of 300-bed hospital; maintenance furnished if desired; salary open; splendid opportunity. D. W. Hartman, Superintendent, The Williamsport Hospital, Williamsport, Pennsylvania.

DIETITIAN—Registered; wanted for a fully approved hospital; a good future. Write Albert G. Hahn, Administrator, Deaconess Hospital, Evansville 11, Indiana.

DIETITIAN—Wanted; small hospital, pleasant surroundings, maintenance provided; state salary expected. MO 33, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

DIRECTOR—School of nursing and nursing service; with Bachelor's Degree in Nursing Education and Master's Degree in Nursing Administration; administrative experience required; general hospital, 364-beds plus 113 bassinets. Apply to A. B. Cook, Garfield Memorial Hospital, Washington, D.C.

Terms:

WANT ADVERTISEMENTS

POSITIONS OPEN

GENERAL DUTY NURSES—For 150-bed hospital; evening and night nurses on medical and surgical services, $221 per month; full maintenance available at minimum rate. Saint Mary Hospital, Pueblo, Colorado.

GENERAL STAFF NURSES—For 200-bed general industrial hospital; eligible for registration in Colorado; salary $200, $15 additional for 3-11 and 11-7; 44-hour week. Apply to Director of Nursing Service, Corwin Hospital, Pueblo, Colorado.

GENERAL DUTY NURSES—$165 per month, full maintenance or $205 with one meal while on duty; 8-hour day, 6-day week, rotating shifts; two weeks' paid vacation after one year. Apply Superintendent, St. Ann's Hospital, P.O. Box 229, Juneau, Alaska.

GENERAL DUTY NURSES—65-bed hospital; 8-hour duty, 6-day week; alternating shifts; two weeks' paid vacation after one year; sick leave after six months; attractively located hospital in northwest Florida; good salary with meals and professional laundry furnished. Apply Superintendent, Jackson Hospital, Marianna, Florida.

GRADUATE NURSES—Beginning salary $180 and full maintenance; 16 holidays; two weeks' vacation; five days off per month. Apply Director of Nurses, Essex County Isolation Hospital, Belleville, New Jersey.

GRADUATE STAFF NURSES—Full or part time in 390-bed hospital connected with medical school; positions open in medical, surgical, pediatric, gynecologic and obstetric departments and in operating room; constantly expanding facilities; 44 hours per week; salary range $200-$215 per month for nurses who can rotate on day, evening, and night duty; exceptional opportunity for furthering education in Vanderbilt University. Write: Director of Nursing Service, Vanderbilt University Hospital, Nashville, Tennessee.

LABORATORY TECHNICIAN — Experienced wanted; registration preferred. Apply Elyria Memorial Hospital, Elyria, Ohio.

LABORATORY TECHNICIAN — Wanted for general work; 150-bed hospital; salary dependent on qualifications. Apply to: Mother Marie, Administrator, Maryview Hospital, Portsmouth, Virginia.

MISCELLANEOUS—Nursing Arts Instructor; salary, $200-$225 plus complete maintenance; Head Nurse medical and surgical floor, salary, $165-$180 plus complete maintenance; General Duty Nurses; salary, $135 plus complete maintenance; $150 for 3:00-11:00 and 11:00-7:00 shifts; if nurse lives out cash allowance of $40 plus meals and uniform laundry; 44 hour week, 28 days' vacation, 8 holidays and 10 days' sick leave per year; yearly increases in salary; easy transportation to New York City. Apply to Jennie A. Baker, Director of Nursing, East Orange General Hospital, East Orange, New Jersey.

(Continued on page 216)

LABORATORY TECHNICIAN—Wanted for 235-bed tuberculosis hospital; 1 hour from Chicago; $230 per month with complete maintenance. Write Superintendent, J. O. Farramore Hospital, Crown Point, Indiana.

LABORATORY and X-RAY TECHNICIAN—General Duty Nurses; salary good with complete maintenance. Apply, Superintendent of Nurses, Waynesboro Community Hospital, Waynesboro, Virginia.

LIBRARIAN—Record; assistant, with excellent opportunity for advancement; fine employee benefits; salary dependent upon experience; general hospital of 400-beds. Personnel Department, The Christ Hospital, Cincinnati, Ohio.

NURSE ANESTHETISTS—Two, well-qualified wanted; salary open. Address: Administrator, Memorial Mission Hospital, Asheville, North Carolina.

NURSE—Graduate for supervisory position in 200-bed private hospital, treating all types of mental patients; one hour from New York city; salary $215 to $235 according to experience, with maintenance available at cost of $35 per month; 5-day, 40-hour, 4 week vacation, 10 day sick leave. South Oaks, Box 467, Amityville, L. I., New York.

NURSES—For 400-bed hospital; 44-hour week; salary average from $200 to $250 a month; additional salary for evening and night duty; Pediatric Head Nurse, Clinical Instructor and general duty staff nurses. Apply Director of Nursing Service, Mercy Hospital, Chicago, Illinois.

The Famous DePUY RAINBOW FRAME

Ideal for the Children's Ward

•

Plated steel construction. Comes in large (No. 505) and medium (No. 506) sizes.

•

Photo courtesy St. Mary's Hospital, Grand Rapids, Mich.

•

Fracture Catalog sent on request.

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Over 50 Years of Continuous Service to Hospitals.

MH 2-49

DePUY MANUFACTURING COMPANY, Warsaw, Ind.

New! Dormitory Furniture

BY HILL-ROM

The large desk provides ample space for reference books and papers—also for lamp, radio, etc.

Showing the easy accessibility of the chest drawers. These drawers open and close easily and quietly.

Bed and bolster serve as lounge during day. One or more bolsters may be used in this way to make a settee.

Compact Bedroom-Living Room Combination Units for Nurses, Students, Internes

Here's HILL-ROM's answer to the problem of providing convenient, comfortable and attractive living quarters for students, nurses and internes—at money-saving cost. The unit consists of a bed and bolster, a three-in-one chest-vanity-desk, and a handy wall shelf for books, radio, clock, etc. Illustrated folder giving complete information and showing many different suggested arrangements for single and double rooms will be sent on request.

HILL-ROM COMPANY, INC., BATESVILLE, INDIANA

HILL-ROM

Furniture for the Modern Hospital

HANOVIA'S INSPECTOLITE

(WOODS LIGHT)

Valuable in Diagnosis

- Filtered Ultraviolet Rays, generated by the Hanovia Inspectolite, offer a satisfactory method for diagnosing Tinea Capitis and other cutaneous infections.
- Evolving and fading syphilitic maculopapular eruptions are visible under filtered ultraviolet rays.
- Eruption of many chronic dermatoses may also be better discerned with the Hanovia Inspectolite.
- Cutaneous and mucous lesions which do not show definite color contrast with their background, can be seen more distinctly.
- Considerable aid is provided in detecting materials which commonly cause dermatitis venenata.
- Woods Light and Black Light are commonly applied phrases for describing the visible filtered ultraviolet rays useful for fluorescent excitation.

FOR COMPLETE DETAILS, WRITE DEPT. P-20

HANOVIA

CHEMICAL & MANUFACTURING CO.

Special Products Division

NEWARK 5, N. J.

World's oldest and largest manufacturers of Ultraviolet Lamps for the Medical Profession.

WANT ADVERTISEMENTS

POSITIONS OPEN

NURSES WANTED—Registered nurses and registered psychiatric nurses (men and women) for state hospital assignments, for general duty, hospital work, tuberculosis and psychiatry; also registered psychiatric nurses with college degree as instructors of affiliating schools of psychiatric nursing; good salaries; opportunity for advancement; excellent retirement and insurance plan. Write: Division of Personnel Service, Department of Public Welfare, State Armory, Springfield, Illinois.

NURSE ANESTHETIST—For a 102-bed general hospital, pleasant environment, excellent opportunity, appropriate salary and maintenance. Apply to Administrator, Northeastern Hospital, Philadelphia 34, Pennsylvania.

OBSTETRIC SUPERVISOR—Also Operating Room Supervisor; for 200-bed California hospital; 5-day week; salary open; maintenance available. Apply Director of Nurses, Santa Barbara Cottage Hospital, California.

OBSTETRICAL SUPERVISOR—And Assistant Supervisor wanted; 400-bed hospital in western New York state; obstetrical division 65 beds; responsible for administration of division and instruction of student nurses; salary open. MO 32, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

OBSTETRICAL NURSES—California hospital on San Francisco bay, forty minutes from that city; five day week; salary $225 per month if post graduate or experienced; $10 additional for evening and night hours; maintenance available. Director of Nursing, Alameda Hospital, Alameda, California.

OPERATING ROOM NURSES—California hospital on San Francisco bay; forty minutes from that city; 100 beds; five day week; salary $225 per month if post graduate or experienced; $10 additional for evening and night hours; additional compensation for on call; maintenance available. Director of Nursing, Alameda Hospital, Alameda, California.

OPERATING ROOM SUPERVISOR—Also a Nursing Arts Instructor for 154-bed hospital connected with a large clinic; capital city. Apply Bismarck Evangelical Hospital, Bismarck, North Dakota.

RADIOLOGIST—Excellent opportunity for a radiologist in a 325-bed hospital located in a large midwestern city; in reply, state qualifications and availability. MO 34, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

RECORD LIBRARIAN—Registered, wanted; or one with considerable experience and eligible for registration; this is 290-bed hospital using Standard Nomenclature; one meal provided; salary open. Duval Medical Center, Jacksonville, Florida.

REGISTERED NURSES—For general duty on all shifts and in all departments of new modern hospital just opening. Address Director of Nurses, East Tennessee Baptist Hospital, Blount Avenue, Knoxville, Tennessee.

SCIENCE INSTRUCTOR—Excellent opportunity; for approved school of nursing; 400-bed general hospital; special employee benefits. For details, apply Personnel Director, The Christ Hospital, Cincinnati, Ohio.

SUPERINTENDENT OF NURSES—Pontiac General Hospital, Pontiac, Michigan. Opportunity to reorganize and improve nursing service as recommended by recent professional survey; applicants should be aggressive and adaptable, have wide background and considerable administrative experience in nursing, and education equivalent to college graduation with courses in nursing administration; salary $3780-$4680 with annual increments of $180; two increases in first year; maintenance available at nominal charges; modern 190-bed plant, large intern-resident program, excellent supporting services, single director; municipal retirement system, liberal sick leave and vacation, tenure under city merit system; educational and cultural opportunities in Detroit one hour away by public transportation; official application and supporting data should be filed by 5:00 p.m., Saturday, February 19, 1949; oral interviews Saturday, March 5, 1949, for candidates selected on personal qualifications. Application blanks furnished on request to Personnel Director, City of Pontiac, Pontiac 14, Michigan.

SUPERINTENDENT OF NURSES—Wanted; experienced and well-qualified for a 182-bed hospital with training school; salary open. Address: Administrator, Memorial Mission Hospital, Asheville, North Carolina.

(Continued on page 218)

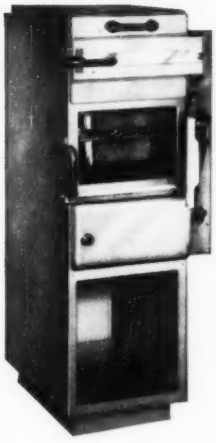
DEBS SILVER for Lasting Service

There is nothing finer for serving cheer with your food than to serve your patients' meals on DEBS fine silver. Its beauty of design and rich texture have the knack of making even the simplest menus more inviting. You'll find that the 18 per cent Nickel Silver Base, EXTRA heavily plated with Sterling means durability with low replacement—things to think of in these days of rising prices. When you can obtain this superb quality at such reasonable cost, we believe it is worthy of your serious consideration. Inquire today to find how wise and economical it is to add DEBS Fine Silver to *your* institution.

DEBS

HOSPITAL SUPPLIES, INC.
118 South Clinton Street • Chicago 6, Illinois

Steamcraft



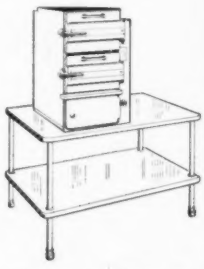
Operators of Smaller Kitchens:

Steamcraft IS FOR YOU

ARE you one of the few progressive institutions still "getting along" without a steam cooker? Sure, you can do without a steamer, as you can without many another modern work-saving, expense-saving convenience.

But why do it the *hard* way? Give yourself a break, and *help* your help. Cut out wrestling with heavy stock pots on your ranges. They take time and fuel to heat up, have to be watched, boil over, boil dry, food burns to the bottom and they have to be scoured.

Steamcraft is a pony in size, but a *workhorse* in action. It has two cooking compartments and holds as many as six of your regular cafeteria pans. Fueled by piped or tank gas, or electricity, it has automatic water feed and time clock control, which cuts down to warming heat when cooking is done. Only 32" high, it sets on one of your own tables or can be furnished with standard base as shown. You will find it the *star performer* in your kitchen.



Showing installation on your own table.

Get all the facts TODAY from your jobber or from us. Ask for folder SCR-1. Cleveland Range has many models in all sizes for direct steam, gas or electric operation.

THE CLEVELAND RANGE COMPANY

STEAMCRAFT DIVISION

3333 LAKESIDE AVENUE, CLEVELAND 14, OHIO

Steamcraft COOKER

60° Room for Short Carry of Fresh Foods

Quick-freezer Has Shelf Plates Held at −15° to −20° F.

THE LAST WORD IN HOSPITAL REFRIGERATION

This installation at the Waynesboro (Penna.) Hospital includes a quick-freezer, a frozen-food storage, a long-term storage, a 60-degree room and an ice-making system. The two ammonia compressors divide the load at suitable temperature levels: each machine is large enough to carry the entire system. Full-automatic control is used.

Cooling System is in the Building with the Laundry and Garage

The Waynesboro Hospital has 58 beds and 20 bassinets. In addition to this new refrigerating plant, it has complete air conditioning for both its operating rooms.

Temperature Averages 30° to 36° in Fruit and Vegetable Room

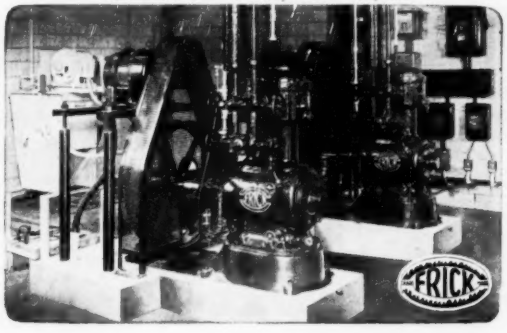
For the ultimate in refrigerating, ice-making, and air conditioning equipment, look to

DEPENDABLE REFRIGERATION SINCE 1882

FRICK CO.

WAYNESBORO, PENNA., U.S.A.

Two Frick Refrigerating Machines, Ice-making System and Automatic Control Board at the Waynesboro Hospital



WANT ADVERTISEMENTS

POSITIONS OPEN

SUPERINTENDENT—Position open for hospital superintendent in central California (45 beds); require Registered Nurse with management and purchasing experience; applicants should give age, experience, educational background, salary expected, references; permanent position for qualified person; appointment by March 15th. MO 35, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

SUPERVISOR—Administrative for hours 3-11; Medical Supervisor who can teach drugs and solutions and materia medica; salary $230 to $255 per month, including one meal and uniform laundry. Write Associate Director, Nursing Service, The Toledo Hospital, 2142 North Cove Boulevard, Toledo 6, Ohio.

TECHNICIAN—Qualified to do laboratory and x-ray work in fully approved 60-bed hospital; salary open; relief available for time off duty. NQ 306, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

INTERSTATE HOSPITAL AND PERSONNEL BUREAU
Miss Elsie Dey, Director
332 Bulkley Building
Cleveland, Ohio

ADMINISTRATORS—(a) Outstanding 200-bed hospital, Ohio; salary open. (b) 150-bed hospital, midwest. (c) 85-bed hospital, western New York. (d) 65-bed Iowa hospital. (e) 100-bed hospital, Maryland.

DIRECTORS—(a) 500-bed teaching hospital; southwest; large medical center to be developed. (b) Assistant; 200-bed hospital, southern Ohio.

DIRECTORS OF NURSING—(a) 450-bed private hospital; graduate staff; diagnostic clinic. (b) 500-bed teaching hospital; southeast. (c) 250-bed hospital, suburb New York. (d) 300-bed hospital, Pennsylvania; $4200, maintenance.

DIRECTORS OF NURSING—(a) 125-bed hospital, Ohio; open June; $350, maintenance. (b) 150-bed hospitals, Illinois, Indiana, Michigan, Wisconsin, Idaho, Florida, Carolinas, Virginia; $4000.

ANESTHETISTS—East; midwest; south; $325, maintenance; also Texas and West Coast.

INSTRUCTORS—Large teaching hospital; south.

EDUCATIONAL DIRECTORS—(a) 350-bed hospital, southern Ohio; $375. (b) East; $325.

SUPERVISORS—(a) Night; 200-bed hospital, Ohio; $250. (b) Operating room; 300-bed modern hospital; midwest; $300, maintenance. (c) Obstetrics; $250. (d) Contagion; $275.

TECHNICIANS—(a) Chief; Ohio; $275. (b) X-ray; Michigan; $200, maintenance. (c) Physiotherapist; 200-bed Pennsylvania hospital; $250.

DIETITIANS—(a) Administrative; large teaching hospital; east; $5000. (b) 450-bed hospital; south. (c) Midwest; $275. (d) Therapeutic; teaching dietitians; $250.

HOUSEKEEPERS—(a) Michigan, $225. (b) Ohio.

THE MEDICAL BUREAU
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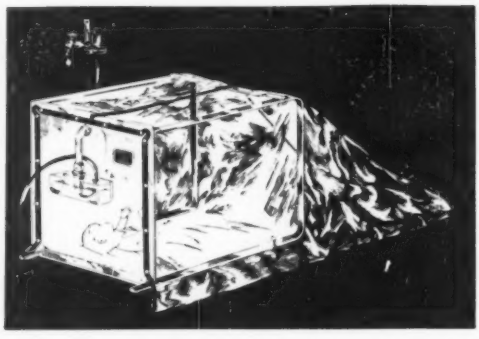
ADMINISTRATORS—(a) Medical; to succeed nationally known administrator planning retirement. (b) Medical; teaching hospital, 1200 beds. (c) Lay or medical; teaching hospital, 400 beds; expansion program. (d) Lay; 75-bed general hospital to be opened April; town of 20,000, middle west. (e) Lay; hospital group, 700 beds; expansion program; university medical center. (f) General hospital, 400 beds; western city, 250,000. (g) Clinic manager; one of leading private practice groups; west. (h) Clinic manager; 12-man group; university medical center; east. (i) Nurse administrator; new hospital, 60 beds; east. (j) Nurse or lay; general, 175 beds; middle west. (k) Public relations director; one of leading medical schools; several affiliated hospitals; outstanding man required. MH2-1.

ANESTHETISTS—(a) Modern general hospital, well staffed; one of the larger towns in Alaska; $4500. (b) To join staff, 16-man clinic; south; $4200. (c) One of leading hospitals in Chicago area; $250, maintenance, up.

(Continued on page 220)

THE CROUPETTE*



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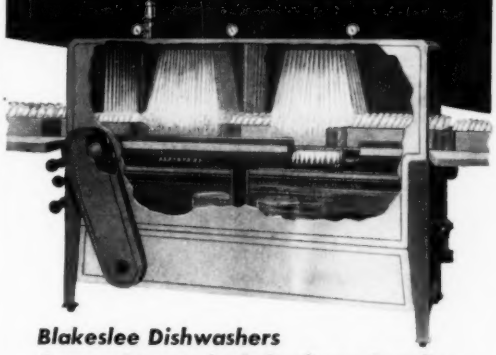

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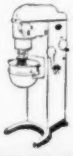

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POSITIONS OPEN

MEDICAL BUREAU—Continued

(d) General hospital, 100 beds; Pacific northwest; minimum, $3600. (e) Small, general hospital; university medical center; middle west; $350, maintenance. MH2-2.

DIETITIANS (a) Chief; fairly large hospital; fashionable winter resort city; west. (b) Chief; 300-bed hospital; college town, New England. (c) Chief; large hospital; winter resort town on Gulf of Mexico. (d) Nutritionist; health organization; Chicago area. (e) Chief; children's hospital, unit, university medical center; east. (f) Therapeutic dietitian; university medical center; east. (g) Two assistants; 300-bed hospital; recent graduate eligible; east. MH2-3

DIRECTORS OF NURSES (a) One of country's largest hospitals; university affiliation; 300 students; key position in nursing profession. (b) Medical center; more than 1500 beds. (c) General hospital, 200 beds; all-graduate staff; American hospital, foreign city; minimum, $4000, maintenance, transportation; degree unnecessary. (d) Dean; university hospital; 300 students. (e) 400 beds; medical school affiliation; collegiate program; $5000-$6000, maintenance. (f) Assistant director; teaching hospital, conducting school for affiliates in psychiatric nursing; university medical center; south. (g) Assistant director; 200-bed hospital affiliated with group clinic; all-graduate staff; $4800; west. MH2-4

MEDICAL BUREAU—Continued

FACULTY APPOINTMENTS—(a) Nursing arts instructor; university school; four-year course; quarters available on campus; $3900. (b) Educational director; large general hospital; staff of 15 instructors; department has affiliates from 20 other hospitals; $4400; university medical center; middle west. (c) Instructor, qualified to organize school of nursing, new general hospital; South America. (d) Educational director; training school conducted under American auspices outside Continental United States; knowledge of French desirable. (e) Health director; collegiate school; duties include teaching public health; west. (f) Instructor, science; general hospital, having expansion program; large city in United States dependency; around $300. (g) Educational director; affiliate school; 300 students; experience with tuberculosis or communicable diseases desirable; $4500, increasing. (h) Clinical, science, nursing arts instructors; fairly large hospital; southwest; $265, maintenance. MH2-5

MEDICAL RECORD LIBRARIANS (a) General, 300-bed hospital; vicinity New York City; $250, maintenance. (b) New hospital, 300 beds; university center; west. (c) University hospital; department conducting school for librarians; university medical center. (d) General, 250-bed hospital; university town, east. MH2-6

PERSONNEL DIRECTOR General hospital, 400 beds; considerable experience required; middle west. MH2-7.

PHARMACISTS (a) Fairly large hospital; around $4800; California. (b) Chief; general

(Continued on page 222)

MEDICAL BUREAU—Continued

hospital, 300 beds; university medical center; middle west. (c) Fairly large hospital; Hawaii. (d) Assistant; hospital of moderate size; southern California. MH2-8.

SUPERVISORS (a) Operating room; also, assistant; general, voluntary hospital, 175 patients; town of 50,000, southwest; salaries $300 and $250, complete maintenance. (b) Obstetrical; one of leading hospitals in California; approximately 2,000 deliveries annually; expansion program includes new department; minimum, $275. (c) Outpatient; new hospital, unit of university group; $300 with eventual advancement to $500; east. (d) Pediatric; voluntary, general hospital, 250 beds; easy commuting distance to two universities; vicinity New York City. (e) Orthopedic and evening supervisors; 200-bed hospital; southwest. MH2-9.

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ANESTHETIST $3600 per year plus partial maintenance; 247-bed approved hospital; east.

DIRECTOR OF NURSING—Large hospital, New York area; salary high.

DIETITIAN Chief; 265-bed Pennsylvania; to $3000 plus maintenance.

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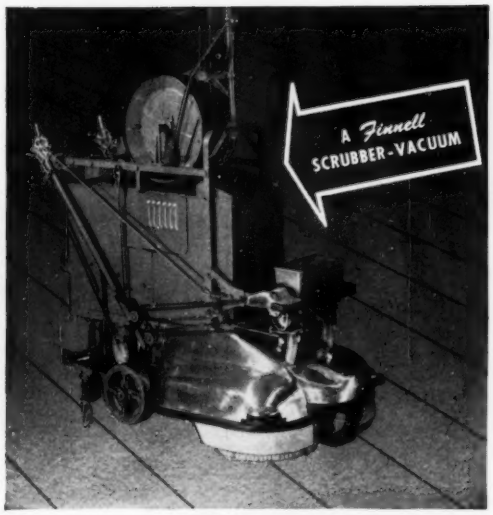

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TECHNICIANS—LABORATORY—(a) Chief; 250-bed; $2700 and meals. (b) Blood bank supervisor; New England; $3000, plus maintenance. (c) Laboratory X-Ray; Ohio; $300. (d) Physiotherapy; male or female; New York; $250.

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ASSISTANT DIRECTOR OF NURSES—Outstanding opportunity in 300-bed approved hospital in eastern medical center; $4000, maintenance.

(Continued on page 224)

WOODWARD—Continued

DIRECTORS OF NURSES—(a) Approved 100-bed general hospital with accredited school; $4200, maintenance; attractive western location. (b) For 120-bed approved hospital expanding to 200 beds in popular Michigan summer resort region; $4200, maintenance. (c) Florida resort; 200-bed approved hospital with accredited school; $5000 yearly.

EDUCATIONAL DIRECTORS—(a) Advisory and counciling duties for fourteen nursing schools in southeastern state; degree required; $4000 per annum. (b) For 200-bed approved general hospital with five year collegiate program, in attractive Chicago suburb; $3000, maintenance.

INSTRUCTORS—(a) Clinical; 100-bed approved hospital in college town near Chicago; $3000, maintenance. (b) Nursing arts; 130-bed approved hospital with accredited nursing school; near east; $3600, maintenance. (c) Science; 200-bed approved hospital with accredited school for nurses in well known southwestern winter resort; $3200, maintenance. (d) Assistant professor, nursing arts, eastern university school of nursing; $3900 yearly.

SUPERVISORS—(a) Pediatric; full charge pediatric department in 400-bed California hospital; post-graduate work required; some college; $3000 minimum. (b) Surgical floor; charge 45-bed department in 150-bed approved hospital, Chicago suburb; $2750, maintenance. (c) Operating room; to head large department in 400-bed southern hospital; Must be well qualified; $3600, maintenance. (d) Obstetrical; full charge of all units in department; 100-bed approved hospital attractively located in midwest college town; $3250, maintenance.

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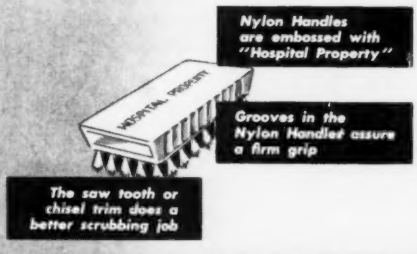

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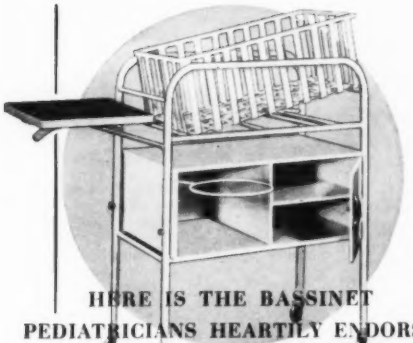

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(Continued on page 228)

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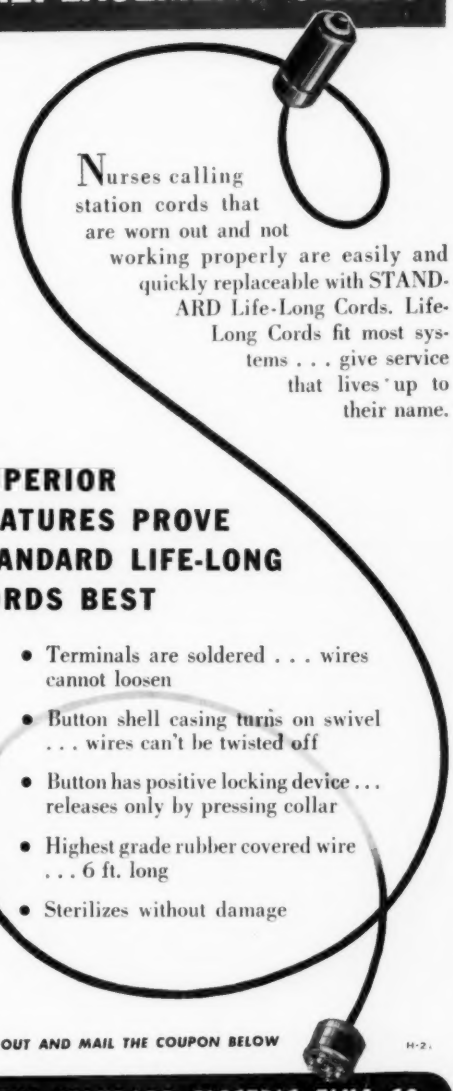

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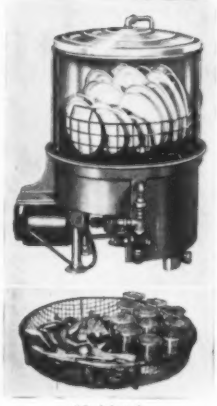
JACKSON DISHWASHERS



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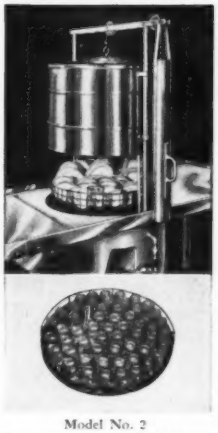

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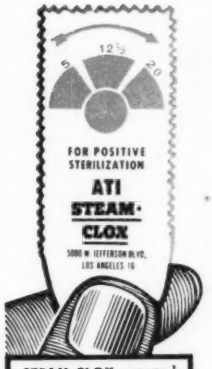

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What's New for Hospitals

FEBRUARY 1949 Edited by BESSIE COVERT

Picker Spotfilmer

The new Picker Spotfilmer for doing sequence spotfilm radiograms is motor-driven. A push button in the handle, under the left thumb of the operator so that the right hand is always free for palpation, controls the movement of the cassette into or out of the fluoroscopic field. An automatic selector index permits the whole area to be exposed, or the film can be divided into halves or quarters.

The type B-2 fluoroscopic screen in the Spotfilmer is 11 by 14 inches and is so mounted that palpation behind it is unhindered. A Lysholm Grid and compression cone diaphragm are mounted in twin channels on the underside and a lead rubber apron to protect the radiologist swings around to the end or to the side, depending upon need. **Picker X-Ray Corporation, Dept. MH, 300 Fourth Ave., New York 10. (Key No. 418)**

Room Air Conditioners

The Fedders ½ and ¾ h.p. window type room air conditioners have restyled cabinets finished in baked ivory enamel which is resistant to alcohol and cigarette burns. The new ivory cabinets have been especially designed for hospitals and private homes. The mechanical units are the fine Fedders quality and are rated at 5500 and 8000 B.T.U. respectively. **Fedders-Quigan Corp., Dep't. MH, Buffalo 7, N. Y. (Key No. 419)**

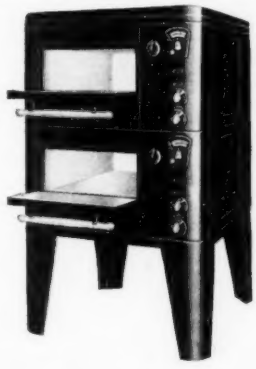
Open-End Tumbler

The new Huebsch "42" is a larger open end tumbler for use where heavy loads and large volume drying are required. This 4 coil laundry tumbler is 42 inches in diameter and 42 inches in depth. It has all the features of the smaller Huebsch open end tumblers and is designed for fast drying time of from 80 to 100 pounds dry weight. It has a one lever temperature control and spun-lock cylinder and shell construction. It is designed for easy loading and unloading and quick accessibility for maintenance. **Huebsch Mfg. Co., Dept. MH, 3744 N. Booth, Milwaukee 12, Wis. (Key No. 420)**

Electric Oven

A new line of electric ovens has been developed by Despatch Oven Company. Sizes of the redesigned models range from No. 338 with 20 by 30 by 9 or 12 inch decks to No. 345 with 57 by 60 by 9 or 12 inch decks. Each size is available with either 1, 2 or 3 decks, each deck consisting of a complete unit.

Features of the new ovens include an indicating control which gives at a glance both the temperature at which



the oven is set and the actual temperature of the working chamber; an exhaust damper easily adjusted by a convenient handle on the control panel; control panel with control switch, 3 heat switches for the upper and lower heating element and indicating control adjusting knob; durable construction, and simplicity of design which facilitates baking control and maintenance. Standard finish of the line is black satin Dulux enamel but other finishes are available. **Despatch Oven Co., Minneapolis 14, Minn. (Key No. 421)**

Diagnostic X-Ray Apparatus

The Maxiscope 500 is a radically new type of diagnostic x-ray apparatus with 44 new features incorporated into the design and operation. New features include: the use of photo-timing which mechanizes the determination of exposure time; an optional 9 position spotfilm device, all positions viewable without film inversion; automatic protection from excess radiation when the bucky diaphragm is removed from the fluoroscopic field; a pedal-controlled, variable-speed hydraulic motor-drive for angulating the table; automatic centering of exposure areas; high voltage, having been increased from 100 to 300 kv and offering wide latitude; height of the radiographic tube stand which permits a 60 inch distance from focal spot to table top; focal-table distance increased for fluoroscopy; increased cross-travel for fluoroscopy, and a 30 degree Trendelenburg position.

The table is so designed that either a rotating or stationary anode tube may be employed for fluoroscopy and the front of the table is completely unobstructed to facilitate handling of patients and controls. The top is easily removed for periodic inspection. **General Electric X-Ray Corp., Dept. MH, 4855 W. McGeoch Ave., Milwaukee 14, Wis. (Key No. 422)**

Ac'cent, Protein Derivative

Ac'cent is a natural sodium salt of the amino acid which occurs naturally in all vegetable and animal protein and is offered in pure, unadulterated, crystal form for addition to the preparation and

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cooking of foods to heighten the flavor. This glutamic acid product adds no flavor, aroma or color of its own but helps maintain flavor between the time of cooking and serving and makes foods more palatable. A mono sodium glutamate, it brings out and intensifies the natural flavor of foods and stimulates the taste buds. It is a pure vegetable product.

Ac'cent is packaged in a metal container with a slip cover closure and an inner metal seal meshed in to afford greater protection to the product which is sealed into a cellophane bag within the metal can. It is available in 1 pound and 10 pound cans and in 100 pound drums. **Amino Products Div., International Minerals & Chemical Corp., Dept. MH, 20 N. Wacker Drive, Chicago 6. (Key No. 423)**

Invalid Lifter

The Porto-Lift is a new hydraulically operated invalid lifter designed to lift patients gently while in bed, from bed to wheel chair and return, to automobile or ambulance, and to handle any other patient lifting need. It is quickly adjusted to the size of any patient and is tested to lift 500 pounds. Seat and back straps make the lifter useful in handling even completely paralyzed patients. The Porto-Lift can also be used to raise helpless patients onto the bed pan.

Extension legs fold inward for moving patient in the Porto-Lift through narrow doors and an optional double arm accessory may be used by a patient as mobile crutches to help regain use of the legs. The Porto-Lift is streamlined in design and has a bronze metallic finish. **Porto-Lift Mfg. Co., Dept. MH, 1410 N. Larch St., Lansing 5, Mich. (Key No. 424)**

Surgical Accessories

Surgical stools and basin stands in stainless steel for the operating room are now available in streamlined designs

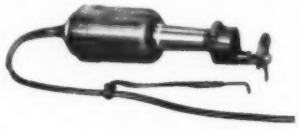
providing the utmost in practicability with minimum areas to be kept clean. Hollow tube construction makes the units light in weight and the new design offers increased strength, easy maneuverability and scientifically distributed weight to resist stress and strain.

The stool has a triangularly shaped, adjustable seat and one piece triangular legs and is comfortable to use. The basin stands have triangular, one piece tubing uprights and 3 inch ball bearing swivel casters. **American Hospital Supply Corporation, Dept. MH, Evanston, Ill. (Key No. 425)**

Stryker Bone Saw

The new Stryker Bone Saw which has been in process of development and testing for over a year is now in production and available to the field. Designed with a unique oscillating type blade, the new electric power saw cuts bone efficiently without catching in the draping material or throwing blood or infectious matter.

Equipped with five blades which are adaptable to many varieties of bone surgery, the saw is complete with foot switch, an aluminum carrying case lined with rubber and the five differently designed blades mounted in a blade holder. The entire unit, including motor, cord,



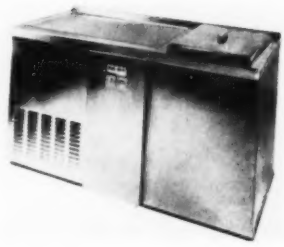
blades and blade holder, can be sterilized in an autoclave without special handling. The new saw is designed to ensure safety for the patient and for the surgeon and his assistants. **Orthopedic Frame Co., Dept. MH, 409 E. Michigan Ave., Kalamazoo, Mich. (Key No. 426)**

Plastic Tableware

Russel Wright, industrial designer, has styled a new set of plastic dinnerware developed especially for institutional use. The set is attractive in appearance and highly functional in design to permit easy stacking and handling. Known as Meladur, the set is made of Melmac, a plastic material especially well adapted for use in dinnerware since it has the appearance of china, is virtually unbreakable and quiet in use. It is tasteless, odorless and nontoxic and is impervious to grease and unaffected by food, soaps or detergents.

The set consists of cup, saucer, dinner plate, combination salad and bread and butter plate, soup bowl, cereal bowl and fruit bowl and is available in tan, blue or white. **Plastics Div., General American Transportation Co., Dept. MH, 135 S. La Salle St., Chicago 3. (Key No. 427)**

Ice Cube Maker



The new Ice-Flo is a completely automatic ice cube making machine which is available in various sizes to fit the needs of a single department, where several units might be used throughout the hospital, or of a complete institution.

The machine produces crystal clear ice cubes at the point of use, 1320 to 12,500 per day in single or multiple installations. Ice-Flo cubes are frozen in molds which form the bottom of a water tank. When frozen solid, they are automatically defrosted and float to the top of the water in the tank where they are carried over a dam and deposited in a dry storage bunker. The cubes do not mat together and are of two dimensions, thus being suitable for most uses.

Finished in stainless steel, the units are table height, are simple to operate and are designed for sanitary, economical operation. **Ice-Flo Corp., Dept. MH, Lonsdale, R. I. (Key No. 428)**

Pneophore

The Pneophore is a valve arrangement that administers oxygen with intermittent positive pressure, omitting the possibility of damaging lung tissue by suction. It can also be used for carrying nebulized drugs effectively into a large part of the respiratory system to treat various pulmonary ailments in which the lungs or parts of the lungs are inactive. Accepted by the Council on Physical Medicine of the American Medical Association, the Pneophore follows the natural breathing pattern on conscious patients without effort and cycles about 12 to 25 times per minute where breathing has stopped.

The device can be used in emergency cases of drowning and other types of asphyxia and has proved successful in cases of poliomyelitis with respiratory arrest. Oxygen delivery pressure is adjusted by a regulator to that recommended by the attending physician. The Pneophore is simple in design and adaptable for use with any oxygen supply. **Mine Safety Appliances Co., Dept. MH, N. Braddock St., Pittsburgh 8, Pa. (Key No. 429)**

Address manufacturers for further information and prices—or use Readers' Service blank on page 240

Orange Juice for Infants

Bib is a specially processed orange juice developed for infant feeding. A product of thorough research, Bib is specially strained for free-flowing bottle feeding, is pasteurized and hermetically sealed in sterilized containers. Processed from carefully selected fruit, the product is a standardized source of vitamin C with high nutritional value and safeguarded natural flavor. It has been accepted by the Council on Foods and Nutrition of the American Medical Association as a reliable source of vitamin C for infant feeding. Its use eliminates the time and trouble of squeezing, straining and sterilizing fresh orange juice. Uniform sweetness is controlled by minimal addition of dextrose. **The Bib Corporation, Dept. MH, Lakeland, Fla. (Key No. 430)**

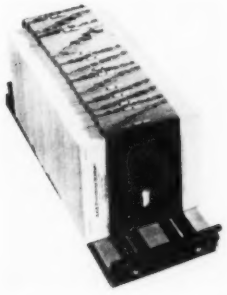
Ophthalmoscope

The new Quad-Disc Ophthalmoscope has instantly positionable color filters for red-free, green-free, daylight and incandescent light together with aperture sizes in large, medium, pin-hole and vertical slit. Any color filter may be used with any size aperture by instant finger-tip selection. All color filters and aperture sizes are built into the instrument.

The exceptionally wide lens range permits 117 different dioptric values. Other features include a May type prism and hand-made lamp with precision centered filament as well as a detachable forehead rest for stability when the instrument is in use. **National Electric Instrument Co., Inc., Dept. MH, 92-21 Corona Ave., Elmhurst, L.I., N.Y. (Key No. 431)**

Paper Sorters

The new Sort-O-Mat Direct Vision paper sorters developed sometime ago by Yawman and Erbe are now available in steel in a new model in which many



changes have been made, resulting in improved operation.

The Sort-O-Mat is a vertical sorter and since papers stand on edge, space is saved. Alphabetic sorting is done at one time with this new model to the first two letters of each name and a second time through sorts to the fourth letter. Subjective, numeric, geographic or special combination sorting is also provided. Automatic expansion provides a wide filing V between guides and light compression keeps papers flat. A round hole in the sorter provides a sight check throughout for any missed papers during the stripping operation. **Yawman and Erbe Mfg. Co., Dept. MH, Rochester 3, N. Y. (Key No. 432)**

Electric Typewriter

The new IBM electric typewriters are compact, fully streamlined and finished in a soft tone of gray. The Navy blue keys are finger contoured and the mechanism beneath them is covered by a keyplate to improve appearance and prevent the accumulation of dust.

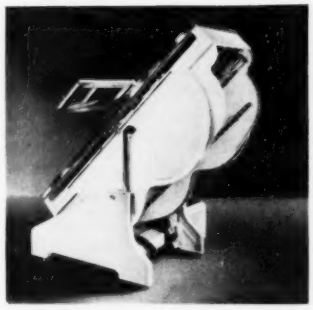
The new machine retains the light key touch for performing all the heavy

operations which is a feature of earlier models and the new features include: readily-adjusted multiple copy control; four position ribbon control; keyboard margin set; electric ribbon rewind, and line position reset. The new machine is available in the standard model and also in the executive model which can be had with any one of four type faces. **International Business Machines Corp., Dept. MH, 590 Madison Ave., New York 22. (Key No. 433)**

Suture "Steriljar"

The new "steriljar" packaging of Scanlan surgical sutures is designed to eliminate time in handling and sterilization in preparation for surgery. The sterile suture tubes are sealed in a germicidal solution in the "steriljars," packed two or three dozen to a jar, depending upon size. Sutures are always visible in the glass jar and always ready for use. The plastic screw top permits repeated use of the jar and keeps alcohol from evaporating or spilling. **The Ohio Chemical & Mfg. Co., Dept. MH, Madison, Wis. (Key No. 434)**

Supertilt X-Ray Table



A true 45 degree Trendelenburg position can be attained with the new Keleket "C" Supertilt Table. The table was developed with the help of leading radiologists and has undergone five years of research, testing and practical service. It is available in three models; radiographic-fluoroscopic, radiographic only or fluoroscopic only. Exclusive Keleket features ensure safe, easy operation and the table offers the radiologist increased facility in performance together with easy visualization.

A geared head motor drive and double geared segments drive the table from both sides. Table angulation may be changed smoothly and automatically from horizontal to 55 degrees in 12 seconds and 135 degrees of angulation, from 45 degrees Trendelenburg through horizontal to vertical, is possible with the new table. Operator-patient safety, rigidity, accuracy and ease of operation are features of the Supertilt. **The Kelley-Koett Mfg. Co., Dept. MH, Covington, Ky. (Key No. 435)**

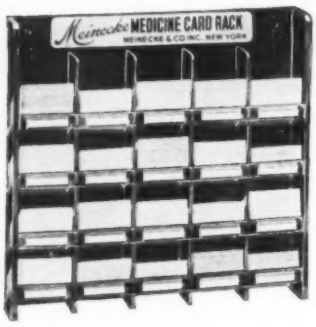
Water Tempering Controller

The new Symmons thermostatic Tempering Controller valve is designed to maintain constant predetermined water temperatures at any outlet where it is installed, regardless of temperature variations. It may be installed anywhere along the line for perfect zone control, is interchangeable and easily removed. The dial is calibrated in 10 degree units with a 5 degree space between so that temperatures can be accurately set. Thus when it is necessary to have very hot water at some outlets, the new valve can be installed at other outlets to control the temperature of the water and prevent waste of hot water.

A solid fill bellows, mounted out of water in a protected chamber open to atmosphere, actuates the valve. It is available in ¾ inch and 1 inch sizes and is designed to last the life of the installation. **Symmons Engineering Co., Dept. MH, 791 Tremont Place, Boston 8, Mass. (Key No. 436)**

Address manufacturers for further information and prices—or use Readers' Service blank on page 240

Medicine Card Rack



The new medicine card rack developed by Meinecke is designed for the orderly storage and use of colored medicine cards. Made of transparent Plexiglas, the rack has 20 separate compartments, each holding at least 40 medicine cards. The sloping shelves prevent cards from falling out of the compartments and any spaces in excess of those required for the hospital's dispensing technic can be used to store extra cards.

Solid brass nameplates identify the contents of each compartment which is so designed that cards can be quickly and easily inserted or removed. The rack is attractive in appearance and has predrilled holes for hanging on the medicine cabinet door or on any convenient wall space. It is 11⅜ by 11 by 1¾ inches in size and weighs less than ½ pound. **Meinecke & Company, Inc., Dept. MH, 225 Varick St., New York 14. (Key No. 437)**

Model MT Dishwasher

The new Universal Model MT automatic dishwasher has an electric push button control device which automatically times a 45 second wash cycle and a 12 second rinse cycle. The dishwasher shuts off automatically at the end of the timed cycle, thus saving hot water and power.

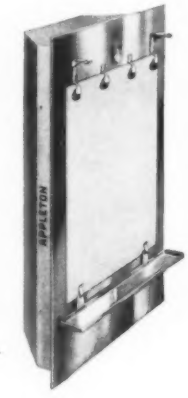
This new automatic push button control has also been added to the Universal Model M door type machine and can also be had for the corner model E, the smaller door model HD and the new roll top counter model B. **Universal Washing Machinery Co., Dept. MH, Nutley 10, N. J. (Key No. 438)**

Small Floor Machine

The new Holt HST 12 is a small machine for floor care which should prove a valuable addition to maintenance equipment for use where traffic is heavy and there is need to polish the most traveled area frequently and the whole floor only periodically. It is a silent running, versatile, twin brush machine, light and economical enough for special uses but highly efficient and built for any type of floor care. Attachments make it possible for the machine to wax, steel wool, polish, scrub or sand any type of floor or floor covering. Special handle grips can be attached for using the unit as a handy polisher for table and desk tops, walls and other areas. **Holt Mfg. Co., Dept. MH, 651 20th St., Oakland 12, Calif. (Key No. 439)**

X-Ray Film Illuminator

The type "EFUX" Appleton explosion-proof x-ray film illuminator is a redesigned unit developed for flush mounting in hospital operating rooms. The glass cover panel is of sturdy construction with four chrome plated roller clips at top of the glass to hold x-ray



film. Two extended hinge clips are also furnished to support the wet film holder and a drip tray has been added.

The metal cabinet is installed flush in the wall and the fixture mounted in the cabinet. Line wires are connected to the connection block located under the screw cover in the lower housing and all other wiring and sealing is completed at the factory. **Appleton Electric Co., Dept. MH, 1701 Wellington Ave., Chicago 13. (Key No. 440)**

Maintenance Tool

The new Red-E-Basin Wrench is designed to speed and simplify the work of applying and removing fittings which are all but inaccessible. Made from high strength alloy steel forgings with grip-lock teeth carefully machined and case-hardened for long service, the wrench is a durable, quality tool. The jaw automatically grips round, square or hexagon parts. **American Die & Tool Co., Dept. MH, Reading, Pa. (Key No. 441)**

Saniglastic Pad

The Saniglastic pad is designed to cover the hospital mattress, thus providing complete protection. Made of foam rubber with hermetically sealed plastic cover, the pad is available in ¼ or ¾ inch thicknesses. The plastic cover, which completely surrounds the foam rubber pad, can be washed with soap and water, sterilized with any cold disinfectant and is easily replaced if necessary.

This resilient, protective pad provides cool protection between the patient and the mattress, reducing the possibility of bed sores and discomfort. Use of the pad simplifies bed making since the pad covers the entire mattress, reduces laundry per bed and increases patient comfort.

The company has also developed Saniglastic bed pillows for comfort and anti-allergenic properties, surgical pillows, and a new type collar for respirators, all made of foam rubber with hermetically sealed plastic covers. **Saniglastic, Dept. MH, 805 Madison Ave., So. Milwaukee, Wis. (Key No. 442)**

Aluminum Chair

An aluminum utility chair has been introduced recently for general use in patients' rooms, dining and lunch rooms, offices and other places where a comfortable straight chair is needed. The frame is made of natural aluminum which will keep its attractive appearance, will not scratch or stain and is light in weight. Upholstery of the back and seat can be specified in standard hair felt and cotton or foam rubber with Goodform plastic or fabric covering material.

The chair back is somewhat flared at the top and the aluminum frame prevents snagging of hosiery or fabrics. The new chair, known as #4310, is durable, attractive, comfortable and requires a minimum of maintenance. **General Fireproofing Co., Dept. MH, Youngstown 1, Ohio. (Key No. 443)**

Address manufacturers for further information and prices—or use Readers' Service blank on page 240

Nursing Unit

The Davol "Anti-Colic" Nurser is now available in 4 ounce size for small feedings and for orange juice, water and other purposes. The bottle has eight sides to prevent rolling, and its slimmer size makes it easier to handle and to store in the refrigerator. The 1¼ inch opening makes the bottle easy to fill and to clean and the 4 ounce scale on the new size and the 8 ounce on the earlier bottle are graduated to one-half ounce and are easily read. The bottles are resistant to heat and cold.

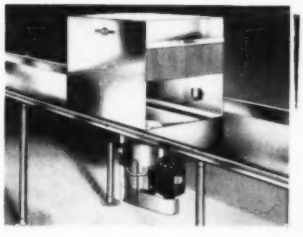
The new "Anti-Colic" dual-purpose nipple has an all round tab which is covered by a plastic collar. The nipple is inverted and covered with a handy, rubber seal inside the collar when the bottle is filled and stored. The seal is removed and the nipple turned tip up with a simple motion when ready for use. The collar can be loosened or tightened to control flow, through the air vent in the nipple, of the contents of the bottle. **Davol Rubber Co., Dept. MH, Providence 2, R. I. (Key No. 444)**

Anti-Slip Ceramic Tile

Careful research and development work have gone into a new anti-slip vitrified ceramic tile recently introduced. It is designed to provide the attractive appearance and cleanliness possible with ceramic tile with an anti-slip quality which makes it particularly desirable for use in corridors, entrance lobbies, kitchens, dining rooms and many other parts of the hospital.

The new tile has a 15 per cent abrasive content which has passed severe tests with respect to minimum absorption, durability and effectiveness of the anti-slip surface. The abrasive permeates the entire thickness of the tile but is scarcely noticeable in appearance. The low absorption prevents fouling or color loss in the tiles. **The Safe Tread Company, Inc., Dept. MH, 30 Vesey St., New York 7. (Key No. 445)**

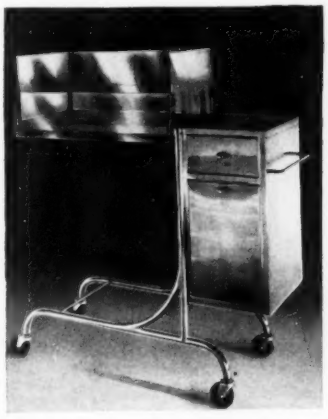
Pre-Washer for Dishes



The ConDishner is a prewasher through which dishes and silverware pass en route to the dishwasher. It works automatically, the water turning on as the rack of tableware is pushed into the ConDishner and turning off automatically as the rack is removed. Garbage is washed from the dishes, ground into particles fine enough to pass through to the sewer with no handling, and the dishes are rinsed and heated. The trap design prevents loss of silverware that may drop through the rack and no garbage is carried into the dishwasher to clog it. Tableware comes out of the dishwasher cleaner, with less detergent required. **Thermo Cuber Co., Inc., Dept. MH, 2120 N. Southport Ave., Chicago 14. (Key No. 446)**

Linde Bassinet

Developed by Edward I. Linde of Hospital Accessories Company, the Linde All-Purpose Bassinet is designed to serve both in the nursery for individual care technic and in the mother's



room for "rooming-in" technic. It is so designed that the base will roll under the mother's bed, placing the plastic basket directly over the bed in easy position for the mother. The storage space, consisting of a drawer and cabinet, is easily accessible by the mother from the bed and similarly accessible to the nurse when used in the nursery. The drawers open from either side.

The bassinet is completely mobile and has the following features: a stainless steel tubing frame which is counterbalanced and mounted on 3 inch ball-bearing swivel casters; a Plexiglas basket with hinged drop sides at the correct height to facilitate mother care; basket rests in a stainless steel frame that has an automatic tilting friction device, and drawer and cabinet large enough to hold a 24 hour supply of materials needed for care of an infant. **Hospital Accessories Co., Dept. MH, 792 Nostrand Ave., Brooklyn 16, N. Y. (Key No. 447)**

Mueller Currentrol

The new single unit Mueller Currentrol provides an all-inclusive range of cautery power for the heaviest major surgery down through a continuous range to a light current suitable for the most delicate eye work. It is also a stepless, shockproof controller for the miniature surgical lamps of light carriers, endoscopic, diagnostic and trans-illuminating instruments and takes the place of two or more ordinary transformers.

Currentrol provides positive duplication of operative results at corresponding control settings. It can be used with all types and all sizes of cautery tips and connecting cords without adapters. It is easily portable with a permanently attached line cord which coils into an integral compartment of the compact steel case. Currentrol operates on 110 volts, 60 cycles, A.C. **V. Mueller & Co., Dept. MH, 408 S. Honore St., Chicago 12. (Key No. 448)**

Bulk Ice Maker

A new portable bulk ice maker has been developed to provide a low cost, convenient source of pure ice. It is available in 4 sizes, 250, 500, 1000 and 2000 pounds per day in approximately 12 hours of freezing time. Ice is produced in 50 and 100 pound blocks or the unit can be fitted with dividers to produce ice cubes. An ice crusher can be furnished in conjunction with the equipment if desired.

Because the walls of the freezing tank are refrigerated, the freezing cans are exposed to even and extensive prime refrigerated surface, assuring even and rapid freezing without the use of a brine agitator. Ice cans are constructed of heavy galvanized steel designed for long life and rough handling. The units are available in either electric motor or gasoline engine driven models. **Reco Products Division, Refrigeration Engineering Corp., Dept. MH, 2020 Naudain St., Philadelphia 46, Pa. (Key No. 449)**

Address manufacturers for further information and prices—or use Readers' Service blank on page 240

Antiseptic Surgical Soap

Antiseptic Septisol is a surgical soap containing hexachlorophene, commonly called G-11, as its active antiseptic ingredient. Use of this new antiseptic soap for surgical scrub-up is claimed by the manufacturer to reduce scrub-up time; give superoir bacteriological cleanliness; reduce skin bacteria one hundredfold; eliminate scrubbing hands and arms with brushes; eliminate the need for alcohol and iodine rinses, and provide an invisible bacteriostatic film on the skin which holds the bacterial count at low levels.

In addition to its use for surgical scrub-up procedures, the manufacturer recommends Antiseptic Septisol for routine and preoperative use on patients; for cleansing traumatic wounds; for the various uses of soap in obstetrics and gynecology; as an aid in the prevention of pyogenic skin infections, and for routine use by nurses, ward attendants, food handlers and other kitchen personnel. **Vestal, Incorporated, Dept. MH, 4963 Manchester, St. Louis 10, Mo. (Key No. 450)**

Cut-Film Viewer

A new Fluoro-Record cut film viewer, Model F-273, has been announced for use in reading the 70 mm. cut film exposed in the Fairchild Fluoro-Record cameras, either the automatic model with adapter back or the cut film model.

Spring clips on either side of the ground glass viewing panel hold the film in position for reading and the film may be slipped under either the right or left hand clip. The illumination of the viewing panel is by incandescent light, the intensity of which is controlled by a rheostat. Film can be inspected either with or without magnification when in place. The unit is of all metal aluminum alloy castings finished in black enamel. **Fairchild Camera & Instrument Corp., Dept. MH, 88-06 Van Wyck Blvd., Jamaica 1, N. Y. (Key No. 451)**

Space Deodorant

Good-Aire is the name given to the new space deodorant which, in actual hospital tests, proved effective in removing even the most offensive odors. The result of three years of research and development, Good-Aire is an aerosol product which is dispensed by a spray which is affixed to the container. Using the principle of liquefied gas to propel small particles of concentrated material into the atmosphere, Good-Aire is said to eliminate offensive odors within 30 seconds from the time the spray is released. **Bridgeport Brass Co., Dept. MH, Bridgeport 2, Conn. (Key No. 452)**

Blue-Dot Nebulizer

The O.E.M. Blue-Dot Nebulizers have been developed for aerosol administration in sino-bronchial respiratory conditions. To meet the demands for correct therapeutic procedure, the new nebulizer is being manufactured in three designs to provide the different sprays necessary and to reduce treatment time.

The Sinusillin Nebulizer produces a dense, large particle mist for the treatment of sinus infection; the Bronchial Nebulizer provides the dense, fine particle mist required for the treatment of bronchiectasis and related conditions, and the Sino-Bronchial Nebulizer supplies both large and fine particle spray, one at either end. The new nebulizers permit nebulization by oxygen tank, hand bulb or pressure pump. **Oxygen Equipment Mfg. Corp., Dept. MH, 405 E. 62nd St., New York 21. (Key No. 453)**

Moduline Laboratory Furniture

The new line of laboratory furniture introduced by A. S. Aloe Company is the result of three years of research and planning with demonstration and test installations in selected laboratories. The resulting streamlined, all metal line of sectional laboratory furniture is known as Moduline.

Each of the 35 carefully designed units is built in standard architectural widths of 24, 35 and 47 inches and permits versatility in arranging cabinets, sinks and other items for routine or highly specialized work in an available area. Individual units are easily bolted together and may be readily rearranged at minimum expense should requirements change. The Moduline cabinets are designed with concealed hinges and pre-punched splash-backs for convenience in mounting utilities without loss of table working space. Other features include stainless steel tops and sturdy understructures with special baked-on finish to provide an acid, alkali and solvent resistant surface. **A. S. Aloe Company, Dept. MH, 1831 Olive St., St. Louis 3, Mo. (Key No. 454)**

Pharmaceuticals

Iberol

Iberol is a new iron, vitamin B complex and liver concentrate tablet for use in the treatment of iron deficiency anemia. It is supplied in bottles of 100, 500 and 1000 tablets. **Abbott Laboratories, Dept. MH, North Chicago, Ill. (Key No. 455)**

96 Hour Penicillin

Crystalline procaine penicillin G in peanut oil-C.S.C. is a sterile suspension of micronized crystalline procaine penicillin G in refined peanut oil with 2 per cent aluminum monostearate added. Each cc. provides 300,000 units of penicillin for intramuscular injection which disintegrates slowly in the tissues, releasing its penicillin over prolonged periods, thus leading to therapeutic penicillin blood levels for 96 hours in most patients. It is available in 10 cc. rubber stoppered serum-type vials and in 1 cc. size glass cartridges for use in the C.S.C. disposable and permanent syringes. **C.S.C. Pharmaceuticals, Div. of Commercial Solvents Corp., Dept. MH, 17 E. 42nd St., New York 17. (Key No. 456)**

Penicillin Troches With Benzocaine

Crystalline Penicillin G Troches with Benzocaine are designed to provide quickly a high level of penicillin in the saliva and to soothe the pain resulting from inflammation without numbing. The troches are white in color and pleasantly flavored with peppermint. They are available in bottles of 20, each troche containing 5,000 units of Crystalline Sodium Penicillin G plus 5 mg. of benzocaine. **Bristol Laboratories, Inc., Dept. MH, Syracuse 1, N. Y. (Key No. 457)**

A and B Specific Substances

Purified blood group specific substances A and B for addition to group O blood in order to neutralize the anti-A and anti-B isoagglutinins that might be present are now available through Sharp and Dohme. The substances used for this purpose are derived from porcine and equine stomachs and are capable of neutralizing the antibodies in the donor's serum after the pattern of antigen-antibody reactions. The solution is supplied in rubber stoppered vials with aluminum closure as a sterile, isotonic solution. Each vial contains one transfusion unit of group A and group B specific substances to be added to 500 cc. of group O blood. **Sharp & Dohme, Inc., Dept. MH, Philadelphia 1, Pa. (Key No. 458)**

Address manufacturers for further information and prices—or use Readers' Service blank on page 240

Menagen Capsules

Menagen is a mixture of estrogenic factors which is virtually odorless and without unpleasant taste, for oral treatment of the menopausal syndrome and other female disorders. This highly concentrated and refined crystallizate of estrogenic substances in a suitable vehicle is available in capsule form, 10,000 International units each, in bottles of 100 and 1000. **Parke, Davis & Co., Dept. MH, Detroit 32, Mich. (Key No. 459)**

Penicillin G

Crystalline Penicillin G Buffered 250,000 unit tablets, scored, have been developed by Upjohn for use in treatment of infections caused by penicillin-susceptible organisms and for prophylaxis against secondary infections following tonsillectomy or tooth extraction.

Another penicillin product developed by this company is an ophthalmic ointment in which the crystalline penicillin G is suspended in finely divided particles in a base that is specifically designed to preserve stability of the penicillin while facilitating rapid spreading. It is supplied in 1 drachm tubes with applicator tip. **The Upjohn Co., Dept. MH, Kalamazoo 99, Mich. (Key No. 460)**

Penicillin Products

Procaine Penicillin G in oil, employing sesame oil as a carrying agent to provide better suspension of the penicillin, with 2 per cent aluminum monostearate to prolong blood levels, is marketed by Cutter in 10 cc. vials with 300,000 units of penicillin per cc. The new product will be known as Hypercillin.

Cutter also announces the availability of 500,000 and 1,000,000 unit water soluble crystalline potassium penicillin G.

Pen-Troches, 5,000 units, for oral administration in treating infections of the oral cavity caused by penicillin-sensitive organisms, are now available in bulk quantities of 250 and 500, packed in moisture-proof jars. **Cutter Laboratories, Dept. MH, Berkeley 1, Calif. (Key No. 461)**

Gramoderm

Gramoderm is an antibiotic skin ointment, each gram containing .025 mg. of gramicidin, the principal active fraction of tyrothricin, in a base composed of Procutan, a new hypo-allergenic, penetrating base. The ointment is designed for the treatment of all skin infections due to gram-positive organisms. It is supplied in collapsible tubes containing 20 grams. **Schering Corp., Dept. MH, Bloomfield, N. J. (Key No. 462)**

Product Literature

• **"This Formica World"** is a new external house organ, the first issue of which appeared in October. This attractively laid out and printed booklet, illustrated in full color and in black and white and employing color throughout most effectively, is being published by The Formica Company, 4614 Spring Grove Ave., Cincinnati 32, Ohio. The editorial material contains much of interest to any executive, including a "sight seeing tour" through the new Terrace Plaza Hotel in Cincinnati, how Formica is used in airplanes, the story of Pregwood, a combination of wood and plastic, and on page 14, of particular interest to hospital administrators, the story of Formica in hospitals. The magazine is being sent to the company's customers and potential customers as well as to employes to acquaint them with new developments and applications of Formica products. **(Key No. 463)**

• Bibliotherapy, Inc., 41 Park Row, New York 7, has published a booklet, **"So You Are to Be Our Patient,"** which can be used by any hospital for distribution to patients. The booklet is written as a guide to patients and to provide detailed answers to their questions, thus saving time for nurses and aids as well as promoting hospital public relations. It is so designed that the particular regulations, procedures and information for any hospital can be inserted so that the booklet fits the particular institution, thus saving the hospital a considerable amount over composition and printing of its own booklet. **(Key No. 464)**

• **Catalog W-55** is a comprehensive, attractively designed and complete 80 page booklet giving full details on the line of drains and plumbing specialties developed by Wade Manufacturing Co., Elgin, Ill. A full index makes it possible for the administrator or maintenance engineer to find information quickly and conveniently on drains, valves, grease interceptors, pumps, sealed air chambers and other products. Type, size, dimension, weight and price of all items are included as well as selector tables for determining roof leader sizes, tabulated information on the correction of water hammer and complete tables for the correct sizing of grease interceptors. **(Key No. 465)**

• **"Paper Cups and Containers at Your Service"** is the title of an alphabetical directory of the foods and drinks that can be served in paper with recommendations as to the size, shape and style of container designed for each. The booklet is available from the Public Health Commission of the Paper Cup and Container Institute, 1790 Broadway, New York 19. **(Key No. 466)**

• **"Planning the Hospital Laundry"** is the title of a new booklet issued by United States Hoffman Machinery Corp., 105 Fourth Ave., New York 3, containing recommendations and data on planning a laundry for general hospitals from 40 to 200 beds. Published through the courtesy of the U. S. Public Health Service, the booklet was prepared by the Institutional Division of U. S. Hoffman Machinery Corp. as a part of Hoffman's engineering advisory service maintained especially to aid architects and engineers in the planning and development of the institutional laundry. Planning, functions of laundry equipment, equipment needed for hospitals of various sizes, layout sketches, service data chart, diagrammatic sketches of equipment and other data are included. **(Key No. 467)**

• **"A Guide to Interior Design"** is the title of a booklet written by Abel Faidy, architect-designer, and published by the Royal Metal Mfg. Co., 175 N. Michigan Ave., Chicago 1. While not written specifically for hospitals, the booklet contains information which should be helpful to the administrator in making decisions regarding color, material and arrangement of furniture. Subjects covered include how to select colors, relation of color and materials, hints on utilizing space to the best advantage and similar material. **(Key No. 468)**

• Several new pamphlets pertaining to steel office equipment have been issued by Berger Mfg. Div., Republic Steel Corp., Republic Bldg., Cleveland 1, Ohio. In addition to catalog and price lists on standard steel office equipment, 4 attractive pamphlets have been prepared on **"7 Answers to Your Storage Problems," "Berger Steel Filing Equipment," "Berger Steel Transfer Cases"** and **"Berger Bookshelf Units." (Key No. 469)**

• **Catalog No. 3-48** issued by The Loxit Moulding Co., 1217 W. Washington Blvd., Chicago 7, gives comprehensive information on metal mouldings and accessories in aluminum, steel and bronze. In addition, the catalog contains information on how to solve some of the unusual problems in connection with the application of mouldings. It is fully illustrated and indexed. **(Key No. 470)**

• A series of teaching filmstrips on rehabilitation and physical medicine is being prepared by the Department of Rehabilitation and Physical Medicine of New York University College of Medicine to cover bed exercises, mat exercises, wheelchair exercises and technics, elevation technics, crutch walking and functional retraining. Ready now are the first three on **Crutch Exercises, and Crutch Walking.** They are available from Filmstrips Inc., 1307 Sixth Ave., New York 19. **(Key No. 471)**

Address manufacturers for further information and prices—or use Readers' Service blank on page 240

• A new **general catalog** on the complete line of laundry equipment offered by Troy Laundry Machinery Division, American Machine and Metals, Inc., East Moline, Ill., has recently been published. Full information, including specifications and dimensions, on all sizes and types of washers, extractors, tumblers, presses, flatwork ironers and accessory equipment is included in the 20 page bulletin printed in two colors, fully illustrated. **(Key No. 472)**

• The second edition of **"Streptomycin Therapy"** has been issued by E. R. Squibb & Sons, 745 Fifth Ave., New York 22. The 48 page booklet covers such subjects as indications, clinical findings, administration, toxicity, table of dosage instructions, table of susceptible micro-organisms, determining streptomycin concentration and a complete bibliography. **(Key No. 473)**

• A complete catalog of **"Lea & Febiger Books"** on medicine, dentistry, pharmacy, nursing, agriculture, physical education and veterinary science is available from Lea & Febiger, Washington Square, Philadelphia 6, Pa. **(Key No. 474)**

• "A prescription for beautiful, longer-lasting hospital interiors" and "The importance of color therapy" are two subjects covered most interestingly in a folder on **"Fabron, the Fabric-Plastic-Lacquer Wall Covering"** recently published by Frederic Blank & Company, Inc., 230 Park Ave., New York 17. Addressed to the hospital administrator, the folder presents factual information on decorating problems which should prove of value when planning decoration of new or existing buildings. A sample swatch of Fabron is attached to the folder which gives information on the qualities of this durable, washable wall covering, including its ability to help prevent the spread of fire, and a list of hospitals using the product. **(Key No. 475)**

TO HELP YOU get information quickly on new products we have provided this convenient Readers' Service Form. Check the numbers of interest to you and mail the coupon to the address given below. If you wish other product information just list the items and we shall make every effort to supply it.

Bessie Covert,
Editor, "What's New for Hospitals"

- ☐ 418 Picker Spotfilmer
- ☐ 419 Room Air Conditioners
- ☐ 420 Open-End Tumbler
- ☐ 421 Electric Oven
- ☐ 422 Maxiscope 500
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- ☐ 425 Surgical Accessories
- ☐ 426 Stryker Bone Saw
- ☐ 427 Meladur Plastic Tableware
- ☐ 428 Ice Cube Maker
- ☐ 429 Pneophore
- ☐ 430 Orange Juice for Infants
- ☐ 431 Ophthalmoscope
- ☐ 432 Paper Sorters
- ☐ 433 Electric Typewriter
- ☐ 434 Suture "Steriljar"
- ☐ 435 Supertilt X-Ray Table
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- ☐ 437 Medicine Card Rack
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- ☐ 442 Seniglastic Pad
- ☐ 443 Aluminum Chair
- ☐ 444 Nursing Unit
- ☐ 445 Anti-Slip Ceramic Tile
- ☐ 446 Pre-Washer for Dishes
- ☐ 447 Linde Bassinet
- ☐ 448 Mueller Currentrol
- ☐ 449 Bulk Ice Maker
- ☐ 450 Antiseptic Septisol
- ☐ 451 Cut-Film Viewer
- ☐ 452 Space Deodorant
- ☐ 453 Blue-Dot Nebulizer
- ☐ 454 Moduline Laboratory Furniture
- ☐ 455 Iberol
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Suppliers' Plant News

Becton, Dickinson & Co., Rutherford, N. J., announces acquisition of a plant in Columbus, Neb., which is scheduled for completion March 1, 1949, and which will be used for experimental operations. Mr. John W. Simmons of the Special Products Sales Division of the company has been appointed General Manager of the new plant. **(Key No. 476)**

Debs Hospital Supplies, Inc., 118 S. Clinton St., Chicago 6, announces that Mr. H. W. Zieler has joined the firm as head of the Scientific Instrument and Laboratory Equipment departments. Mr. Zieler is an authority on microscopy and has lectured on that and related subjects at leading scientific educational institutions. He will expand the departments which he has now taken over to give more complete service to hospitals and laboratories. **(Key No. 477)**

Hoffmann-La Roche, Inc., Nutley 10, N. J., manufacturer of pharmaceuticals, announces appointment of three new vice-presidents: Paul J. Cardinal in charge of the bulk vitamin division, Dr. Max F. Furter in charge of pharmaceutical research and production and Robert A. Hardt in charge of sales and advertising. **(Key No. 478)**

Walter G. Legge Company, Inc., manufacturer of the Legge System of nonslip floor maintenance materials, announces removal of its offices from 11 W. 42nd St. to **101 Park Ave., New York 17. (Key No. 479)**

The Seamless Rubber Co., Surgical Dressings Division, New Haven 3, Conn. has been appointed exclusive distributor to the hospital field for Q-Tips, the line of cotton tipped applicators manufactured by Q-Tips, Inc., Long Island City, N. Y. **(Key No. 480)**

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HEALTH-BUILDING

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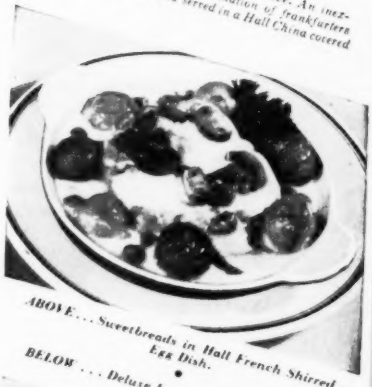

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